PLEASE DIRECT ALL QUESTIONS REGARDING THIS ACTION
TO ANN FROHMAN, GENERAL COUNSEL

BEFORE THE DEPARTMENT OF INSURANCE
STATE OF NEBRASKA

STATE OF NEBRASKA DEPARTMENT OF INSURANCE PETITIONER, VS. UNITED HEALTHCARE GROUP, UNITED HEALTHCARE INSURANCE COMPANY, UNITED HEALTHCARE OF THE MIDLANDS, UNITED BEHAVORIAL HEALTH, MIDWEST SECURITY LIFE RESPONDENTS.	)	PETITION AND NOTICE OF HEARING CAUSE NO. C-1612

Petitioner states and alleges as follows:

1. The Nebraska Department of Insurance ("Department") is a duly designated agency of the State of Nebraska empowered to exercise jurisdiction and control over the licensing of insurers and insurance agents in Nebraska pursuant to Neb. Rev. Stat. §44-101.01, §44-303 and §44-4047 et seq. The Department has jurisdiction over this matter pursuant to the Standard Provisions and Forms, Neb. Rev. Stat. §44-513; General Provisions Covering Life, Sickness, and Accident Insurance, Neb. Rev. Stat. §§44-710.19(1) and 44-792(5)(b); the Unfair Insurance Trade Practices Act, Neb. Rev. Stat. §44-1521 et seq.; the Unfair Insurance Claims Settlement Practices Act, Neb. Rev. Stat. §44-1536 et seq.; the Unauthorized Insurers Act, Neb. Rev. Stat.§ 44-2001 et seq.; the Group Insurance Act, Neb. Rev. Stat. §44-1601 et seq.; the Preferred Provider Organization Act, Neb. Rev. Stat. §44-4101 et seq. the Small Employer Health Insurance Act, Neb. Rev. Stat. §44-5201 et seq.; the Utilization Review Act, Neb. Rev.

NOTICE OF HEARING

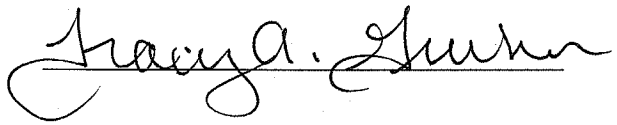
You are hereby notified that a hearing on this matter will be held at the Department of Insurance, 941 "O" Street, Suite 400, Lincoln, Nebraska, on February 14, 2007, at 10:00 a.m. or soon thereafter as the same may be heard.

You are further notified that this hearing will be conducted pursuant to the Administrative Procedure Act, Neb. Rev. Stat. §84-901 et seq. You will have the opportunity to respond and present evidence on your own behalf. You have the right to be represented by legal counsel at your own expense. You have the right to review evidence against you prior to the hearing.

You are also notified that the Department of Insurance may subpoena witnesses to testify against you and that agency subpoenas shall be issued to a party on request. Any witness at the hearing, or any person whose testimony has been submitted in written form, if available, shall be subject to cross-examination by any party as necessary for a full and true disclosure of the facts. This hearing will be an oral proceeding open to the public and shall be recorded by mechanized means. Reasonable accommodations will be provided disabled person upon advance request. The hearing will be transcribed at the request of any party with the expense of the transcription charged to the requesting party. This proceeding will be conducted by the Director of Insurance or by a hearing officer appointed by the Director. The hearing officer will have no prior knowledge of the matters involved in this proceeding. If you fail to appear, the Nebraska Department of Insurance will proceed to hearing, produce evidence and argument and a final decision or order will be forthcoming.

CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing Petition and Notice of Hearing was served upon Respondent by mailing a copy to Respondent United HealthCare Group, 9900 Bren Road East, MN08-808302, Minnetonka, MN 55343, Respondent United HealthCare, 450 Columbus Blvd. 5NB, P.O. Box 150450, Hartford, Connecticut 06115-0450, Respondent United HealthCare of the Midlands, 2717 North 118th Circle, Suite 300, Omaha, Nebraska 68164-9672, Respondent United Behavioral Health, 6300 Olson Memorial Highway, MN010-E151, Golden Valley, Minnesota 55427 and Respondent Midwest Security Life Insurance Company 2700 Midwest Drive, Onalaska, WI 54650-8764by certified mail, return receipt requested, and via Federal Express overnight mail, on this 7th day of December, 2006.



TO: Respondent

FROM: Nebraska Department of Insurance

GENERAL PROCEDURE FOR DEPARTMENT OF INSURANCE HEARINGS

1. The Hearing Officer, who has no knowledge of the case, will open the hearing and will make the Notice of Hearing and Director's Order Appointing the Hearing Officer part of the record. The entire hearing is tape-recorded.

2. The Hearing Officer will identify the attorney for the Department, the attorney for the Respondent, if any, and will state whether the Respondent is present. The Respondent may represent himself or herself. There is no requirement that an attorney represent the Respondent. The Department cannot give you advice about whether or not you should hire an attorney.

3. The Hearing Officer will ask for opening statements, first from the Department, then from the Respondent. An opening statement may be a short summary or a history of facts pertinent to the case. The opening statement is optional.

4. The Hearing Officer will ask the Department and the Respondent to present their cases. The Department will present its evidence first and the Respondent will follow. A presentation may consist of testimony by witnesses, including that of the Respondent, exhibits and testimony by other witnesses. Therefore, the Respondent should bring all that the Respondent wants the Hearing Officer to consider. The parties may object to a witness testifying at the hearing or to an exhibit, which the opposing part wishes to present as evidence.

5. Any witness giving testimony in the proceeding will be sworn. The witness will first be asked questions by the party calling such witness. The opposing party will then have the opportunity to cross-examine that witness. The Hearing Officer also may ask a witness questions.

6. At the conclusion of each party's presentation, the Hearing Officer will ask for a closing statement. The closing statement is optional and may constitute a summary of the evidence presented and why the Respondent should or should not be granted an agent's license by the Department.

7. The Hearing Officer closes the hearing then reviews the evidence and makes a Recommended Finding to the Director. The Director may adopt the recommendation or arrive at a different conclusion. The Respondent may appeal the Director's Order to the Lancaster County District Court within 30 days after receiving the Order.

Stat. §44-5401 et seq.; the Third-Party Administrators Act, Neb. Rev. Stat. §44-5801 et seq.; the Insurers Examination Act, Neb. Rev. Stat. §44-5901 et seq.; the Health Maintenance Organization Act, Neb. Rev. Stat. §44-3292 et seq.; the Managed Care Emergency Services Act, Neb. Rev. Stat. §44-6801 et seq.; the Group Health Plans Act, Neb. Rev. Stat. §44-6901 et seq.; the Managed Care Plan Network Adequacy Act, Neb. Rev. Stat. §44-7101 et seq.; the Health Carrier Grievance Procedure Act, Neb. Rev. Stat. §44-7301 et seq.; and Title 210 of the Nebraska Administrative Code, specifically Chapters 21 and 61. Said jurisdiction and control have been present at all times material hereto.

2. United Healthcare Insurance Group ("UHG") is the parent company for numerous insurance companies, Third-Party Administrators, and Health Maintenance Organizations in the United States. It is the parent company for the aforementioned Respondents.

3. United Healthcare Insurance Company ("UHC") is an insurer licensed to engage in the business of insurance in the State of Nebraska as a foreign insurer.

4. United HealthCare of the Midlands ("UHM") is a Health Maintenance Organization that has a certificate of authority to operate in Nebraska.

5. Midwest Security Life Insurance Company ("Midwest") is a Wisconsin domiciled insurer licensed to conduct business in Nebraska as a foreign insurer. Respondent's registered business address with the Nebraska Department of Insurance is 2700 Midwest Drive, Onalaska, WI 54650-8764. Midwest is subsidiary of UHC Group.

6. United Behavioral Health ("UBH") is currently licensed as a Third Party Administrator in the State of Nebraska, and is part of UHG.

7. United HealthCare Group, UHC, UBH, UHM and Midwest, for purposes of this administrative action, are collectively named "Respondents."

BACKGROUND

8. Commencing in March, 2003, Petitioner experienced an increase in the number of complaints filed by consumers against Respondents. Petitioner met with Respondents on several occasions in an attempt to resolve the complaints, a majority of which pertained to claims handling. In a meeting on September 23, 2004, Respondents assured the Department that Respondents understood the cause of the complaints. Moreover, on November 16, 2004, Respondents met with the Department and provided an action plan in which they would restructure their business practices and take steps to resolve these complaints. On December 9, 2004, another meeting was held in which Respondents updated the Department of their progress.

9. Despite these assurances, consumers continued to complain to the Department. On November 21, 2005, the Department commenced an onsite examination of the market practices of UHC and UHM, in accordance with the provisions of the Insurers Examination Act, Neb. Rev. Stat. § 44-5901 et seq. During the examination, the Department focused upon insurance transactions occurring between July 1, 2003 and June 30, 2004. The Department's exam documented in excess of six hundred violations by UHC and over two hundred violations by UHM with respect to Chapter 44 of Nebraska Revised Statutes. The market conduct examination culminated in draft reports issued October 19, 2005 with final reports filed by the Department on March 24, 2006.

ALLEGATIONS

10. Based upon numerous consumer complaints received by the Department of Insurance, as well as the Department's Market Conduct Report of UHC for activities from July 1, 2003 through June 30, 2004, and the Market Conduct Report for UHM for activities from July

1, 2003 through June 30, 2004, the Nebraska Department of Insurance hereby alleges that the Respondents flagrantly, and in conscious disregarded of Nebraska Insurance Statutes and Rule and Regulations, violated the following: the Small Employer Health Insurance Act, the Health Maintenance Organization Act, the Unauthorized Insurers Act, the Preferred Provider Organization Act, the Utilization Review Act, the Standard Forms Act, the Group Health Plans Act, the Third Party Administrators Act, the Group Insurance Act, the Managed Care Emergency Act, the Unfair Trade Practice Complaint Register Regulation, the Managed Care Plan Network Adequacy Act, General Provisions Covering Life, Sickness and Accident Insurance set forth in Article 7 of Chapter 44 of the Nebraska Revised Statutes, the Insurers Examination Act, the Unfair Trade Practices Act, the Health Carrier Grievance Procedure Act, the Unfair Claims Practices Act, and Unfair Life, Sickness, and Accident Claims Settlement Practices Act, as specified hereafter:

I.

CONSUMER COMPLAINTS AGAINST MIDWEST SECURITY LIFE

A. 06-0637

11. The Unfair Trade Practice Act, specifically Neb. Rev. Stat. §44-1524 states that "It shall be an unfair trade practice in the business of insurance for any insurer to commit any act or practice defined in section 44-1525 if the act or practice (1) is committed flagrantly and in conscious disregard of the Unfair Insurance Trade Practices Act or any rule or regulation adopted pursuant to the act or (2) has been committed with such frequency as to indicate a general business practice to engage in that type of conduct."

12. The Health Carrier Grievance Procedure Act, specifically Neb. Rev. Stat. § 44-7301 et seq., has been in existence since 1998. Neb. Rev. Stat. §44-7308 addresses first-level grievance reviews as follows:

> "(1) If a covered person makes a request to a health carrier for a health care service and the request is denied, the health carrier shall provide the covered person with an explanation of the reasons for the denial, a written notice of how to submit a grievance, and the telephone number to call for information and assistance. The health carrier, at the time of a determination not to certify an admission, a continued stay, or other health care service, shall inform the attending or ordering provider of the right to submit a grievance or a request for an expedited review and, upon request, shall explain the procedures established by the health carrier for initiating a review. A grievance involving an adverse determination may be submitted by the covered person, the covered person's representative, or a provider acting on behalf of a covered person, except that a provider may not submit a grievance involving an adverse determination on behalf of a covered person in a situation in which federal or other state law prohibits a provider from taking that action. A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination have appropriate expertise. A health carrier shall issue a copy of the written decision to a provider who submits a grievance on behalf of a covered person. A health carrier shall conduct a first-level review of a grievance involving an adverse determination in accordance with subsection (3) of this section and section 44-7310, but such a grievance is not subject to the grievance register reporting requirements of section 44-7306 unless it is a written grievance.
>
> (2)(a) A grievance concerning any matter except an adverse determination may be submitted by a covered person or a covered person's representative. A health carrier shall issue a written decision to the covered person or the covered person's representative within fifteen working days after receiving a grievance. The person or persons reviewing the grievance shall not be the same person or persons who made the initial determination denying a claim or handling the matter that is the subject of the grievance. If the health carrier cannot make a decision within fifteen working days due to circumstances beyond the health carrier's control, the health carrier may take up to an additional fifteen working days to issue a written decision, if the health carrier provides written notice to the covered person of the extension and the reasons for the delay on or before the fifteenth working day after receiving a grievance. (b) A covered person does not have the right to attend, or to have a representative in attendance, at the first-level grievance review. A covered person is entitled to submit written material. The health carrier shall provide the covered person the name, address, and telephone number of a person designated to coordinate the grievance review on behalf of the health

carrier. The health carrier shall make these rights known to the covered person within three working days after receiving a grievance.
(3) The written decision issued pursuant to the procedures described in subsections (1) and (2) of this section and section 44-7310 shall contain: (a) The names, titles, and qualifying credentials of the person or persons acting as the reviewer or reviewers participating in the first-level grievance review process; (b) A statement of the reviewers' understanding of the covered person's grievance; (c) The reviewers' decision in clear terms and the contract basis or medical rationale in sufficient detail for the covered person to respond further to the health carrier's position; (d) A reference to the evidence or documentation used as the basis for the decision; (e) In cases involving an adverse determination, the instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used to make the determination; (f) If applicable, a statement indicating: (i) A description of the process to obtain a second-level grievance review of a decision; and (ii) The written procedures governing a second-level review, including any required timeframe for review; and (g) Notice of the covered person's right to contact the director's office. The notice shall contain the telephone number and address of the director's office.

13. In addition, Neb. Rev. Stat. §44-7309 governs the second-level grievance reviews as follows:

"(1) A health carrier that offers managed care plans shall establish a second-level grievance review process for its managed care plans to give those covered persons who are dissatisfied with the first-level grievance review decision the option to request a second-level review, at which the covered person has the right to appear in person before authorized representatives of the health carrier. A health carrier required by this section to establish a second-level grievance review process shall provide covered persons with adequate notice of that option.

(2)(a) With respect to a second-level review of a grievance, a health carrier shall appoint a second-level grievance review panel. A majority of the panel shall be comprised of persons who were not previously involved in the grievance. The panel shall have the legal authority to bind the health carrier to the panel's decision. (b) A health carrier shall ensure that a majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise.

(3) A health carrier's procedures for conducting a second-level panel review shall include the following: (a) The review panel shall schedule and hold a review meeting within forty-five working days after receiving a request from a covered person for a second-level review. In cases in which the covered person cannot appear in person, a health carrier shall offer the covered person the opportunity to communicate with the review panel by conference call or other available

technology; (b) Upon the request of a covered person, a health carrier shall provide to the covered person all relevant information that is not confidential or privileged; (c) A covered person has the right to: (i) Attend the second-level review; (ii) Present his or her cases to the review panel; (iii) Submit supporting material both before and at the review meeting; (iv) Ask questions of any representative of the health carrier; and (v) Be assisted or represented by a person of his of her choice; (d) The notice shall advise the covered person of the rights specified in subdivision (3)(c) of this section; (e) The review shall include (i) documentation of the substance of the grievance and (ii) full investigation of the substance of the grievance, including all known aspects of clinical care involved; and (f) The review panel shall issue a written decision to the covered person within five working days after completing the review meeting."

14. On May 5, 2006, a consumer filed a complaint with the Department of Insurance contending that Midwest failed to provide $500 in chiropractic care benefits. The Department's investigator initiated the investigation on May 10, 2006 with a letter to Midwest. On May 24, 2006, Midwest responded. On June 1, 2006, the Department's investigator sent another letter to Midwest requesting a response as to why the complainant was not notified of his right to contact the Department of Insurance, why the contact information was not provided, why the review timeline was not in accordance with the Grievance Procedure Act, and why the names, titles, and qualifying credentials of the persons acting as the reviewer were not provided to the complainant.

15. On June 22, 2006, Midwest admitted in correspondence that it is their company's policy to combine first-level and second-level appeals into one level. This practice constitutes a flagrant and conscious disregard of Neb. Rev. Stat. §§44-7308 and 44-7309. Midwest admitted that "going forward" the appeal language would include the right to contact the Department of Insurance. This is an admission that prior to that point in time, the contacts between the insured and Midwest did not contain that information. The requirement has been enforce since 1998. The

practice of combining reviews is flagrant and in conscious disregard of Neb. Rev. Stat. §§44-7308(1), 44-7308(3)(g), 44-7308(3)(a) and 44-7308(10).

16. On July 19, 2006, the Department's investigator sent Midwest another letter asking for the names of the individuals serving on the grievance committee along with their titles and their qualifications. Midwest provided a list on August 2, 2006, and stated that a medical doctor advises the panel. Of the seven individuals who may serve on the grievance committee, only two appear to have been health care professionals. This is a violation of Neb. Rev. Stat. §§44-7308(1) and 44-7309(2)(b). Moreover, there was nothing to indicate in the procedures provided by Midwest that the names, titles and qualifying credentials were provided in a letter to complainant or, for that matter, whether or not, by virtue of the information not contained in the letter, if the panel members had appropriate expertise. This is a flagrant and a conscious disregard of Neb. Rev. Stat. §§44-7308(1) and 44-7308(3)(a).

B. 06-1116

17. Neb. Rev. Stat. §44-7307 establishes general grievance procedures as follows:

> (1) Except as specified in section 44-7311, a health carrier shall use written procedures for receiving and resolving grievances from covered persons.
>
> (2)(a) A copy of the grievance procedures, including all forms used to process a grievance, shall be made available to the director upon request. A health carrier shall file annually with the director a certificate of compliance stating that the health carrier has established and maintains grievance procedures that fully comply with the provisions of the Health Carrier Grievance Procedure Act. (b) A description of the grievance procedure shall be set forth in or attached to the policy, certificate, membership booklet, outline of coverage, or other evidence of coverage provided to covered persons. (c) The grievance procedure documents shall include a statement of a covered person's right to contact the director's office for assistance at any time. The statement shall include the telephone number and address of the director.

18. Neb. Rev. Stat. §44-7310 similarly governs the review standards for adverse determinations. It states:

> (1) A health carrier shall establish written procedures for a standard review of an adverse determination. Review procedures shall be available to a covered person and to the provider acting on behalf of a covered person. For purposes of this section, covered person includes the representative of a covered person.
> (2) When reasonably necessary or when requested by the provider acting on behalf of a covered person, standard reviews shall be evaluated by an appropriate clinical peer or peers in the same or similar specialty as would typically manage the case being reviewed. The clinical peer shall not have been involved in the initial adverse determination.
>
> (3) For standard reviews the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within fifteen working days after the request for a review. The written decision shall contain the provisions required in subsection (3) of section 44-7308.
>
> (4) In any case in which the standard review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier that offers managed care plans shall review it as a second-level grievance.

19. On August 21, 2006, the Nebraska Department of Insurance received another complaint about Midwest's failure to provide $500 in chiropractic care benefits. Pursuant to that complaint, the Department's investigator initiated an investigation on August 25, 2006 and wrote Midwest with regard to this issue and seeking additional information.

20. On September 21, 2006, Midwest responded. Three days later, the Department requested additional information regarding how Midwest was in compliance with Neb. Rev. Stat. §44-7308(3)(a)(g) and Neb. Rev. Stat. §44-7310. Midwest's files revealed that they had sent a letter dated March 22, 2006 to the complainant, who was insured by a "PPO Policy" medically underwritten by Midwest. Midwest's letter summarized Midwest's first-level grievance review of

the original claim denial of medical benefits. Midwest failed to provide the complainant the names, titles, and qualifying credentials of the person or persons acting as the review or reviewers participating in the first-level grievance review process. Midwest also failed to provide notice to the complainant of his right to contact the Department of Insurance or the telephone number and address of the Department's office. Midwest noted that their company was working on submitting a compliant policy and procedure to the Department for the "Nebraska Internal Grievance Process" that complies with Nebraska Law. Nonetheless, Midwest flagrantly, and in conscious disregard of the law, violated Neb. Rev. Stat. §§ 44-7308(3)(a) and 44-7308(3)(g).

21. Midwest flagrantly and in conscious disregard of Nebraska insurance law also violated Neb. Rev. Stat. §§ 44-7308(1), 44-7308(3)(a) and 44-7308(3)(g) when, on or around May 4, 2006, Midwest sent to a complainant, an enrollee of a "PPO Plan" underwritten by Midwest, a letter summarizing Midwest's first-level grievance review of another claim denial. Midwest failed to provide to the complainant the names, titles, and qualifying credentials of the person or persons acting as the review or reviewers participating in the first-level grievance review process. Since the letter contained incomplete information, it was unclear, at best, whether or not the reviewing panel had "appropriate expertise" to review the appeal. Midwest similarly failed to provide notice to the complainant of her right to contact the Department of Insurance for assistance or the telephone number and address of the Department's office.

22. Based upon the investigators review of complaint files 06-0637 and 06-1116, the Nebraska Department of Insurance requested a copy of Midwest's grievance procedures. Upon further review, the Department found that Midwest's procedures were not in compliance, and thus in violation of the Heath Carrier Grievance Procedure Act, Neb. Rev. Stat. §44-7301 et seq. The investigation also revealed that Midwest violated Neb. Rev. Stat. §44-7307(2)(a) when it flagrantly

and in conscious disregard of the statute failed to annually file with the director a certificate of compliance stating that the Midwest has established and maintains grievance procedures that fully comply with the provisions of the Health Carrier Grievance Procedure Act.

23. Midwest flagrantly and in conscious disregard of Neb. Rev. Stat. §44-7307(2)(c) violated the aforementioned law when, on or around June 26, 2006, Petitioner received a current copy of Midwest's "Internal Grievance Procedures" which clearly omitted a statement of a covered person's right to contact the Department for assistance at anytime.

24. Midwest flagrantly and in conscious disregard of the law, also violated Neb. Rev. Stat. §44-7308(2)(b), when on or around June 26, 2006, Petitioner received a current copy of Midwest's "Internal Grievance Procedures" which revealed incorrect practices by including statements of Nebraska law that once a grievance has been received by Midwest, a response will be sent in writing "within 5 business days to the Enrollee explaining the Grievance Procedure and the Enrollee's right to appear."

25. Midwest flagranlty and in conscious disregard of the law violated Neb. Rev. Stat. §§44-7308(2)(a) and 44-7309(3)(f) when on or around June 26, 2006, Petitioner received a current copy of "Midwest's Internal Grievance Procedures" which contained another practice in violation of the law upon revealing that Midwest "will review any information the Enrollee presents pertaining to the Grievance, including any new information, the Grievance Committee will meet to review the information, a letter of the Committee's determination will be sent to the Enrolle within 30 days of receiving the Grievance."

26. Midwest flagranlty and in conscious disregard of another grievance law violated Neb. Rev. Stat. §44-7309(1) when on or around June 26, 2006, Petitioner received a current copy

of Midwest's "Internal Grievance Procedures" which reflected another improper practice in that the procedures failed to contain a provision offering Enrollees a second level appeal process or the chance to appear in person before authorized representatives of the health carrier. Midwest also stated in its June 26, 2006 response "[i]t has been our company's process in the past to combine the first and second level appeals into one level." Finally, all aforementioned conducted alleged in paragraphs 16 through 26 herein, also constitute violations of the Unfair Trade Practice Act, specifically Neb. Rev. Stat. §44-1524 et seq.

II.

CONSUMER COMPLAINTS AGAINST UHC

A. 04-2079

27. Neb. Rev. Stat. §44-1525(1) states "Any of the following acts or practices, if committed in violation of section 44-1524, shall be unfair trade practices in the business of insurance"...(11) when any insurer, "upon receipt of a written inquiry from the department, fails to respond to such inquiry or request additional reasonable time to respond within fifteen working days."

28. On November 9, 2004, a complaint was filed against UHC with the Virginia Bureau of Insurance. Since the policy was issued from Nebraska, the complaint was transferred to Nebraska on or about December 9, 2004. The complaint centered on a denial of coverage for temporomandibular joint disorder.

29. On December 15, 2004, a Department of Insurance investigator opened an investigation into the matter and contacted UHC. On January 6, 2005, UHC responded. The

UHC response indicated that they received an appeal from the complainant on June 30, 2004, and, at that time, a first-level appeal was initiated. UHC did not respond to the request until July 22, 2004. UHC decided to uphold the initial coverage denial. A request for a second-level appeal hearing was received in the UHC National Appeals Service Center on August 4, 2004. The hearing was not held until September 22, 2004, and the coverage denial was, once again, upheld.

30. In a December 8, 2005 letter to UHC, the Department asked UHC why the denial letter failed to disclose names and titles of the reviewing panel. The letter also asked UHC to inform the Department how the second-level reviewers were qualified and had the requisite expertise to review these matters considering that the reviewers appeared not to have much, if any, appropriate medical expertise.

31. UHC responded via a January 6, 2006 letter. In that letter, they admitted that the first and second-level determination letters were inadequate, despite this concern having been raised by the Department during its examination of UHC in 2005, and that changes were being made to the letters. However, at that particular time, the letters were in conscious disregard and a flagrant violation of Neb. Rev. Stat. §§44-7308(3) and 44-7309.

32. The letters sent to the complainant and the complainant's physician with regard to the first and second-level appeals were also inadequate per Neb. Rev. Stat. §§44-7308 and 44-7309, as UHC recognized in the January 6, 2006 letter, since the names of the review panel were omitted from the letter to the complainant.

33. In the same January 6, 2006 letter, UHC admitted that a doctor involved in the appeal was not provided documents in a timely manner "due to a backlog of work." This constitutes a conscious disregard and a flagrant violation of Neb. Rev. Stat. §44-7308.

34. Moreover, UHC violated Neb. Rev. Stat. §44-7309(2)(a) by failing to appoint a grievance committee, per the statutory requirements. Anne Gagner, UHC employee, identified two names of the review committee and their titles. One title was Network Management and the other was Sales and Marketing. Under Neb. Rev. Stat. §44-7309(2)(a) and (b), a majority of the panel shall be comprised of persons who were not previously involved in the grievance and the majority of the panel must be health care professionals that have appropriate expertise. The persons on the review panel had none, a violation of this law.

35. Pursuant to Neb. Rev. Stat. §§44-1524 and 44-1525(11), UHC failed to respond to the Department's letter of December 8, 2005. As noted above, the Department asked, with regard to the review panel, "how are these employees qualified and have the required expertise for his type of claim/appeal?" Their response does not provide any qualifications of the panel members, fails to provide any of their medical credentials, and even failed to provide their names. Instead of providing the qualifications, UHC erroneously responded:

> "You also had concerns about our second level panels member's qualifications. Each second level hearing is setup within a certain market and United Healthcare has designated panel members for each market. Our decisions for claims payments are based on our enrollee's Certificate of Coverages and Riders. Each panel member is supplied with all the supporting documentation needed to fully review each appeal based on our enrollee's benefit under their plan."

36. All aforementioned conducted alleged in paragraphs 27 through 35 herein, constitute violations of the Unfair Trade Practice Act, specifically Neb. Rev. Stat. §44-1524 et seq.

B. 04-0627

37. Neb. Rev. Stat. §44-1538(1)(c) states, "For purposes of the Unfair Insurance Claims Settlement Practices Act...(c) Insurer shall mean any person, reciprocal exchange,

interinsurer, Lloyds-type insurer or other similar group which includes incorporated and individual unincorporated underwriters, fraternal benefit society, and other legal entity engaged in the business of insurance, including agents, brokers, insurance consultants, adjusters, and third-party administrators. Insurer shall also mean health maintenance organizations, prepaid limited health service organizations, and dental, optometric, and other similar health service plans."

38. Neb. Rev. Stat. §44-1539 states that "it shall be an unfair claims settlement practice for any domestic, foreign, or alien insurer transacting business in this state to commit an act or practice defined in section 44-1540 if the act or practice (1) is committed flagrantly and in conscious disregard of the Unfair Insurance Claims Settlement Practices Act or any rule or regulation pursuant to the act or (2) has been committed with such frequency as to indicate a general business practice to engage in that type of conduct."

39. Neb. Rev. Stat. §44-1540(1) states "[a]ny of the following acts or practices by an insurer, if committed in violation of section 44-1539, shall be an unfair claims settlement practice: (1) Knowingly misrepresenting to claimants and insureds relevant facts or policy provisions relating to coverages at issue."

40. Nebraska Life and Health Unfair Claims Practice Regulation, specifically Title 210 NAC Ch. 61 (005.01) states that "[n]o agent or insurer shall knowingly misrepresent or conceal form claimants, any pertinent benefits, coverages, or other provisions of any insurance policy or certificate when such beneifts, coverages or other provisions are pertinent to a claim."

41. In addition, Title 210 NAC Ch. 61 (006.02) states that "[e]very insurer, upon receipt of any inquiry from the Director respecting a claim shall furnish the Department, in

duplicate, an adequate response to the inquiry or request additional reasonable time to respond within fifteen (15) days of reciept of such inquiry."

42. On April 7, 2004, a complaint against UHC was received by the Department wherein the complainant believed that they were deceived when they bought the UHC policy because they did not receive a benefit that they thought they would have received, based upon the representations of an agent for UHC. UHC's "Summary of Benefits" that was presented to the Complainant denoted that they would cover a procedure listed under exclusions as long as it is deemed medically necessary by a physician. The complainant chose the most expensive plan believing, based upon the material presented by an UHC agent that it covered more conditions, including gastric bypass surgery.

43. After complainant received the Master Policy ("Certificate of Coverage") it was found that the procedure was not, in fact, covered *at all* despite the language employed in the summary of benefits. According to the complainant, UHC's representative assured complainant that "...these situations are reviewed on a case-by-case basis, with the decision being based on whether the procedure is actually medically necessary." Prior to filing the complaint with the Department, the complainant completed the first-level of appeal with UHC.

44. In the Department's investigation, UHC was specifically asked by the Department how they were in compliance with several statutes, considering the language employed in the UHC Summary of Benefits was inconsistent with the policy language. On May 7, 2004, UHC responded to the Department, admitting it had talked with the complainant and advised the complainant that there are times that UHC will consider gastric bypass surgery but, in this case, based upon a specific exclusion in the complainant's "Certificate of Coverage", the request was denied January 13, 2004. According to UHC, complainant started an appeal with

UHC January 18, 2004, where the initial determination to deny benefits was upheld. UHC also noted that the Summary of Benefits that the complainant was shown is for the "Options PPO" issued in the State of Illinois. Additionally, when asked by the Department's investigator about the issuing agent, UHC did not know the name of the agent. Yet, the Department learned that information when it obtained the UHC application, where the name of the agent, is clearly noted. The application would have been in the possession of UHC once submitted by the agent and a "Certificate of Coverage" issued to the complainant.

45. UHC failed to respond to Petitioner and violated Neb. Rev. Stat. §§44-1524 and 44-1525(11). UHC was also asked to produce a copy of underwriting guidelines/criteria to determine if gastric bypass is medically necessary. UHC failed to provide this information and violated Neb. Rev. Stat. §§44-1524 and 44-1525(11). Additionally, UHC failed to respond and violated Neb. Rev. Stat. §§44-1524 and 44-1525(11), when it did not address the issue as to why they were not in violation of Nebraska law.

46. On May 17, 2004, the complainant informed the Department of Insurance that the agent was from Illinois. The complainant noted that upon receipt of the UHC "Certificate of Coverage," the complainant contacted UHC about the exclusion and was told by UHC "not to worry, that these situations are reviewed on a case-by-case basis, with the decision being based on whether the procedure is actually medically necessary."

47. Based upon the complainant's May 17, 2004 letter, the Department investigator wrote to UHC on May 21, 2004, and asked UHC to address what the UHC agent provided to the complainant and if the information provided was incorrect. UHC was also asked to address the previous comment by UHC, namely, the statement made to the Department in the September 24, 2003 letter, "...that there are times that UHC will reconsider the gastric bypass surgery based on

the medical condition of the member," and the statement made to the Complainant "not to worry, that these situations are reviewed on a case-by-case basis, with the decision being based on whether the procedure is actually medically necessary." The Department investigator also asked UHC, once again, to provide the underwriting criteria employed by UHC to determine if gastric bypass surgery is medically necessary. UHC was also asked why UHC advised an insured that these types of situations are handled on a case by case basis when, in fact, the company will deny the procedure based upon the exclusion and was further asked how this was in compliance with Neb. Rev. Stat. §§44-1539, 44-1540(1).

48. UHC responded on June 18, 2004, asserting that the aforementioned statements were "characterizations" or references to the right of appeal of the determinations. They also stated that they were not in violation of Nebraska law since the agent, from Illinois, sold an Illinois policy and it was not UHC's responsibility since it could not issue an Illinois plan in Nebraska. Under Neb. Rev. Stat. §44-1538(c), the term "Insurer" includes agents of the insurer. UHC is responsible for the actions of its agent. In this case, the agent and UHC sold a policy that was not attainable by a Nebraska resident and, when questioned about it, UHC did not directly tell the complainant, nor the Department for that matter, that the gastric bypass procedure was excluded, rather, that "...these situations are reviewed on a case-by-case basis, with the decision being based on whether the procedure is actually medically necessary." When pressed to provide underwriting criteria, it failed to do so. In this case the complainant could not make an informed decision on whether or not to purchase this product because they were misinformed from the beginning of the purchasing process.

49. Based upon the "characterizations" in paragraph 48, as UHC called them, UHC consciously disregarded and flagrantly violated Neb. Rev. Stat. §§44-1539, 44-1540(1), Title 210

NAC Ch. 61 (005.01), (006.02). The complainant should have been told, at the time of sale by the agent and, subsequently, by UHC directly, that the gastric bypass surgery was excluded.

C. 06-0199

50. Neb. Rev. Stat. §44-1540(3) states that it shall be an unfair claims settlement practice if the insurer "fails to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies."

51. Neb. Rev. Stat. §44-1540(4) states that it shall be an unfair claims settlement practice if the insurer is "not attempting in good faith to effectuate prompt, fair, and equitable settlement of claims submitted in which liability has become reasonably clear."

52. Neb. Rev. Stat. §44-1540(7) states that it shall be an unfair claims settlement practice if the insurer is "[r]efusing to pay claims without conducting a reasonable investigation."

53. On February 2, 2006, a complaint was received by the Nebraska Department of Insurance alleging that UHC failed to properly pay a benefit for a diagnostic colonoscopy. The claim was filed July 14, 2004. On February 8, 2006, the Department investigator initiated an investigation with a letter to UHC asking for information regarding the complaint. UHC responded on March 1, 2006. According to UHC, the claim was processed on July 27, 2004, allegedly in accordance with the "Certificate of Coverage" for 2004.

54. When UHC received the inquiry from the Department, according to UHC, "It was discovered in September 2004 that our claim payment system was not processing scopic procedures correctly." UHC stated that it took "corrective" measures by placing on a bulletin on its website indicating "any claims for colonoscopies and other scopic procedures needed to be processed according to our enrollee's COC portion for diagnostic services."

55. The Department investigator discovered that the complainant's "Certificate of Coverage" for 2004 included a diagnostic service rider that would have paid the colonoscopy at 100% of the allowable cost with no co-payment and no deductible charges. Subsequently, the claim was properly reviewed on February 21, 2006, and an additional $597.07 was paid.

56. Further investigation revealed the UHC's logs indicate that they *knew* in September 2004, that UHC's claim payment system was not processing scopic procedures correctly. That is, a September 13, 2004, UHC phone entry log states: "Please reprocess this claim. Member had no surgery; it was diagnostic. Please reprocess at 100%, if you look at CPT codes and rev codes." Still, UHC did not adjust the claim when put on notice by its' own staff.

57. On March 1, 2006, the Department sent UHC another letter asking about the phone log entry and also asked why the claim was not correctly processed. UHC responded that in order to correct this issue, it had sent educational emails to claims processors in 2004. UHC failed, flagrantly and in conscious disregard of Neb. Rev. Stat. §§44-1524 and 44-1525(11), to address the *specific* question as to why the claim was not processed properly in 2004 when they knew that their claims processing on this particular procedure was in error.

58. UHC also flagrantly and consciously violated Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), and 44-1540(7), when it failed to adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies. UHC was aware in September 2004, that it should have been processed differently and yet failed to pay the claim *until* February 2006. UHC did not, in good faith, settle the claim when they knew it should have been settled, and failed to conduct a reasonable investigation of this matter until prompted to do so by the Department.

59. All aforementioned conducted alleged in paragraphs 53 through 58 herein, also constitute violations of the Unfair Trade Practice Act, specifically Neb. Rev. Stat. §44-1524 et seq.

D. 06-0460

60. Neb. Rev. Stat. §44-1540(13) states that it shall be an unfair claims settlement practice if the insurer is "failing, in the case of the denial of a claim or the offer of a compromise settlement, to promptly provide reasonable and accurate explanation of the basis for such action."

61. Title 210 NAC Ch. 61 (006.01) states that "Every insurer shall, within fifteen (15) days of receipt, acknowledge and respond to any written communication relating to a claim and to all other pertinent communications from a claimant which resasonably suggest that a resplonse is expected. Communication to an agent of an insurer shall be communication to the insurer."

62. Title 210 NAC Ch. 61 (008.02), states "if a claim remains unresolved for fifteen (15) days from the date proof of loss is received, the insurer shall provide the insured a reasonable written explanation for delay. If the investigation remains incomplete, the insurer shall, thirty (30) days from the date on initial notification the claim is unresolved and every thirty (30) days thereafter, send to the insured a reasonable written explanation setting forth the reasons additional time is needed for investigation."

63. On April 3, 2006, the Nebraska Department of Insurance received a complaint alleging numerous issues against UHC. The Nebraska Department of Insurance opened an investigation. Pursuant to that investigation, the Department's investigator sent UHC a letter on April 10, 2006, and UHC responded on April 27, 2006. The Department was especially interested as to why, when UHC eventually responded to the complainant, the spreadsheet that

they sent the complainant contained the correct identification number and name of the complainant, but provided the incorrect claims information. In fact, UHC provided information for an insured from Florida when the complainant was from Nebraska. This constitutes a flagrant violation of Title 210 NAC Ch. 61 (006.01), because it did not contain any of the information requested by complainant.

64. The investigation revealed that the complainant had appealed denials of coverage by UHC. Specifically, UHC initially took a claim form Children's Hospital in Omaha, Nebraska as an inpatient hospital claim resulting from an emergency room visit on September 30, 2005. The claim was received on October 13, 2005. According to the policy, UHC must be notified within one business day of an emergency admission into a facility. In the April 27, 2006 response to the DOI letter, UHC claimed, "At the time the claim was processed, our records did not indicate we had been notified of this stay. For this reason, the claim was denied for no authorization." UHC further determined, and improperly so, that it did not receive adequate notice of the inpatient admission and that it had overpaid Children's Hospital and demanded the full amount back from the hospital. That money was received in March of 2006. The money was returned in error.

65. UHC reviewed their files further and discovered that notification from the hospital was indeed received on October 1, 2005. UHC admitted that "The information received was reviewed by a Field Medical Director and it was determined this inpatient admission was an emergency; therefore, the emergency room visit as well as the inpatient stay should be covered." The claim, which was received on October 13, 2005, was adjusted on April 12, 2006 and $85,344.57 was paid to Children's Hospital plus a late payment interest was also paid in the amount of $4,309.05. UHC knew that the claim should have been paid within fifteen days after

the receipt or, at the very least, it should not have been denied because authorization was given by UHC on October 1, 2005. This practice constitutes a flagrant and conscious disregard of the law, and amounts to ten violations of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), 44-1540(7), and 44-1540(13).

66. UHC also failed to provide the complainant a reasonable explanation for the delay. If any explanation was given, it was not have been reasonable since UHC knew that the claim should have been paid within fifteen days. This not only constitutes a flagrant and conscious violation of the law, but also constitutes ten violations of Title 210 NAC Ch. 61 (006.01), (008.02), (008.04).

67. On May 1, 2006, the Department sent a letter to UHC seeking further information regarding this file. According to the Department's letter, a response was due no later than May 26, 2006. An explicit date was included since UHC had a history of untimely and incomplete responses to Department investigators' inquiries. On May 30, 2006, UHC faxed a response to the Department. The faxed letter denoted the letter was created May 26, 2006, however, the Department, as noted earlier, did not receive the faxed copy (the only copy received), until May 30, 2006. This constitutes a failure to respond and a flagrant and conscious violation of Neb. Rev. Stat. §§44-1524, 44-1525(11) and Title 210 NAC Ch. 61 (006.02).

68. In the aforementioned letter of May 1, 2006, the Department of Insurance asked for an explanation as to why so many claims were denied for "no authorization" and then were subsequently paid, why the authorization was overlooked and what steps had UHC taken to prevent it from happening again. Additionally, UHC's phone log, indicated that this matter should have been taken care of via internal mechanisms. The Department investigator also questioned UHC about why there were no procedures in place to forward appeals received in the

claims processing center to the appeal center in Utah and why the initial payment to the provider was inadequate.

69. In the May 30, 2006 response by UHC, UHC could not explain why they had previously been aware of the need to address the claim but failed to do so. This constitutes an admission that UHC flagrantly violated and consciously disregarded Neb. Rev. Stat. §§44-1539 and 44-1540(3) since they knew that the claim was at issue but yet failed to follow their own procedures to rectify the matter.

70. Furthermore, with regard to the inadequate payment to the Provider, UHC admitted that it incorrectly applied it to the 2005 deductible and after the provider's appeal was received. UHC determined that the deductible was met and an additional $1,914.31 was paid to the provider. UHC flagrantly violated and consciously disregarded Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

71. All aforementioned conducted alleged in paragraphs 63 through 70 herein, constitute violations of the Unfair Trade Practice Act, specifically Neb. Rev. Stat. §44-1524 et seq.

E. 06-0174

72. Neb. Rev. Stat. §44-1540(2) states that it shall be an unfair claims settlement practice if the insurer is "failing to acknowledge with reasonable promptness pertinent communications with respect to claims arising under its policies."

73. Neb. Rev. Stat. §44-1540(8) states that it shall be an unfair claims settlement practice if the insurer is "failing to affirm or deny coverage of a claim within a reasonable time after having completed its investigation related to such claim."

74. Title 210 NAC Ch. 61 (006.03), states that "every insurer, upon receiving notification of claim, shall provide, within fifteen (15) days, the necessary claim forms,

instructions and reasonable assistance so the insured can comply with the insurer's reasonable requirements and also comply with the policy conditions."

75. Title 210 NAC Ch. 61 (008.03), governs the timely processing of claims as follows: "[T]he insurer shall affirm or deny liability on claims within a reasonable time and shall tender payment within fifteen (15) days of affirmation of liability, if the amount of the claim is determined and not in dispute. In claims where multiple coverages are involved or portions of the claim are in dispute, payments to a known payee which are not in dispute should be tendered within fifteen (15) days after receipt by the insurer of settlement information if such payment would terminate the insurer's known liability under that individual coverage or portion of the claim which was not in dispute. This is not withstanding the existence of disputes as to other portions of coverage."

76. On January 27, 2006, a complaint was filed with the Department against UHC, alleging that UHC was not paying claims in a timely fashion or at all. According to the complainant, specific claims from the Mayo Clinic were considered out-of-network benefits by the UHC insurance plan, but were still not properly paid.

77. On February 3, 2006, the Department investigator contacted UHC regarding the complaint. Within the request for information, the Department asked for phone logs and a spreadsheet of the claim history. On February 24, 2006, UHC responded but did not include the aforementioned spreadsheet and included only partial phone logs. This conduct is in violation of Neb. Rev. Stat. §§44-1524 and 44-1525(11).

78. In the February 24, 2006 response, UHC unequivocally stated "...all claims for services rendered to [the complainant] have been processed correctly according to his policy."

Additionally, the letter and subsequent investigation revealed that the complainant's coordination of benefits status had been updated on or about September 8, 2005.

79. On February 28, 2006, the Department investigator once again asked for the spreadsheet from UHC. Finally, after 30 days of the Department's original request, UHC provided a spreadsheet March 3, 2006. Then, on March 8, 2006, Investigator Ems wrote to UHC regarding the claims history. Specifically, there were several Mayo Clinic claims received by UHC on June 17, 2005 but were not processed until November 16, 2005. UHC was asked to explain why it took them five months to process the claims.

80. UHC responded on March 31, 2006 by reiterating that UHC needed some coordination of benefits information, despite the fact that it was *already* provided on September 8, 2005. The claims were sent for processing and were issued on November 16, 2005. However, Investigator Ems asked the company to clarify why it took UHC several months to process the claim even after the coordination of benefits response was received by UHC.

81. UHC responded to the Department investigator on April 28, 2006, and admitted that there was a delay in processing the claim. This admission is completely contrary to the earlier assertion that UHC had processed all claims properly. This delay in processing constitutes a flagrant and conscious disregard of Neb. Rev. Stat. §§44-1540(2), 44-1540(3), 44-1540(4), 44-1540(8), and Title 210 NAC Ch. 61 (006.01), (006.03), (008.02), and (008.03).

82. All aforementioned conduct alleged in paragraphs 76 through 81 herein, constitute violations of the Unfair Trade Practice Act, specifically Neb. Rev. Stat. §44-1524 et seq.

83. Neb. Rev. Stat. §44-1525(1)(a) states "Any of the following acts or practices, if committed in violation of section 44-1524, shall be unfair trade practices in the business of insurance: (1) Making, issuing, circulating, or causing to be made, issued, or circulated any estimate, illustration, circular, statement, sales presentation, omission, or comparison which: (a) Misrepresents the benefits, advantages, conditions, or terms of any policy."

84. Title 210 NAC Ch. 61 (008.01) states that "[w]hen a claim is denied, written notice of denial shall be sent to the claimant within fifteen (15) days of the determination. No insurer shall deny a claim, or portion thereof, on the grounds of a specific policy provision, condition or exclusion unless reference to such provision, condition, or exclusion is included in the denial. The denial must be given in writing, with reasonable and accurate explanation. The claim file of the insurer shall contain documentation of the denial as required by Section 004."

85. On September 17, 2006, the Department received a complaint from a consumer indicating that her surgeon, Dr. David Murowski, had yet to be paid by UHC. The policy of insurance, and the certificate issued were from Nebraska. Dr. Murowski's office contacted UHC numerous times with regard to this claim. Initially, UHC believed that this claim might be a workers compensation claim covered by another insurer.

86. On September 21, 2006, the Department investigator again contacted UHC with regard to these new allegations. On October 16, 2006, UHC responded indicating that on May 15, 2006, UHC received a letter from AIG, the workers compensation carrier, which indicated that AIG would not be issuing payment for the injury and that the claim should be submitted to the health insurance carrier. Upon receipt of the May 15, 2006, UHC forwarded all claims to

their claim adjusters, however, as UHC noted in their October 16, 2006 letter, "the claim from Dr. Morawski was overlooked and not processed."

87. Earlier, on May 31, 2006, Dr. Murowski's office received correspondence from UHC essentially denying the claim since it was UHC's belief that the claim was actually a workers' compensation claim. This is *despite* notification to UHC of the contrary in the AIG letter of May 15, 2006. Immediately upon receipt of UHC's position, Dr. Murowski's office contacted UHC about the claim and, once again, was told that the claim was denied because it was a workers compensation claim. Dr. Murowski's office sent a copy of the workers compensation denial letter along with the claim previous to this time. No other correspondence or contact was made by UHC to Dr. Murowski's office or to the complainant until Dr. Murowski's office, once again, contacted UHC on July 18, 2006. This constitutes a conscious disregard and a flagrant violation of Title 210 NAC Ch. 61 (006.01).

88. According to UHC's internal activity logs, the following notation was made on June 13, 2006: "COB was updated 5/3/06, *there is no other insurance.* Adjust the following claims..." (emphasis added.) On July 18, 2006, Dr. Murowski's office once again checked on the status of the claim. Again Dr. Murowski's office learned that the claim was being denied because UHC asserted that this was a workers compensation claim despite ample proof to the contrary. This constitutes a flagrant violation of Title 210 NAC Ch. 61 (008.01) since the denial of the claim was not reasonable considering that UHC had documentation, in hand, that the claim was not related to workers compensation and that it was a legitimate claim on its policy.

89. On July 19, 2006, Dr. Murowski's office contacted UHC again, and was told that the claim was going to be reprocessed and to allow thirty days for processing. Nebraska's law mandates that a claim needs to be processed in fifteen working days. UHC's statement to Dr.

Murowski's office was a misstatement of policy provisions, in violation of Neb. Rev. Stat. §§44-1524, 44-1525(1)(a), 44-1539, 44-1540(3), and 44-1540(4).

90. On July 19, 2006, according to UHC's internal documents, the following was noted: "Please reconsider. This issue is routed for the second time; we have denial from work comp." On July 26, 2006, Dr. Murowski's office received another "Explanation of Benefits" statement from UHC *denying* the claim because it was workers compensation related. This constitutes a violation of Title 210 NAC Ch. 61 (008.01) since the denial of the claim was not reasonable considering that UHC had documentation, in hand, that the claim was not related to workers compensation and that it was a legitimate claim on the policy.

91. Thereafter, Dr. Murowski's office, once again, contacted UHC informing them that they should have (and which they did) have the workers compensation denial letter on file. UHC stated that unless it came across with each claim, they would continue to deny the claim based upon workers compensation. UHC took down the information and, once again, said to allow thirty days for processing. This constitutes yet another violation of Neb. Rev. Stat. §§44-1524, 44-1525(1)(a), 44-1539, 44-1540(3), and 44-1540(4).

92. Another UHC internal document from July 26, 2006 noted the following: "Provider=David R. Morawski. Denial for workers comp attached." On August 16, 2006, UHC documents reveal that the issue was *escalated* when the following was placed in the file: "SME escalation. Reconsider as we reconsidered other charges for same date of service. Even after sending back many times, we show the claim reconsidered but nothing on payment stts (*sic*)."

93. On August 16, 2006, Dr. Morawski contacted UHC again. After holding for fifteen minutes, UHC told the doctors' office that the claim was processed but there were no *notes* as to how the claim was processed and nothing had been paid. UHC told the doctor's

office that they would send the claim back again and to allow another seven to ten days for review and thirty days for processing. Finally, a supervisor got on the phone and stated that the claim would be paid with interest.

94. Then, according to UHC, on August 18, 2006, Fox Valley Orthopedics contacted UHC regarding the outstanding claim. After discussion, according to UHC, the claim was forwarded for escalated review, despite the fact that other employees at UHC had already noticed the claim had not been paid for several weeks. The claim was finally processed on August 18, 2006 for $1,541.67 and payment issued to Dr. Morawski on September 12, 2006. Neb. Rev. Stat. §44-1540(8) requires that an insurer affirm or deny coverage of a claim within a reasonable time after having completed its investigation related to such claim. UHC flagrantly and in conscious disregard of the aforementioned statue, failed to affirm the claim within a reasonable time, in violation of Neb. Rev. Stat. §44-1524 et seq.

95. As noted above, the investigation should have ceased, at the latest; May 15, 2006, when UHC knew this was not a workers compensation matter. The claim should have been paid within fifteen days, per Title 210 NAC Ch. 61 (008.03). Instead, over eighty days had passed before the claim was processed and it was nearly ninety days before the doctor received his payment. In the letter of October 16, 2006, UHC admitted that it had not processed the matter within fifteen days per the Unfair Claims Settlement Regulation. This violated Title 210 NAC Ch. 61 (008.03).

96. Neb. Rev. Stat. §44-1540(3) requires that an insurer "...adopt and implement reasonable standards for the prompt investigation and settlement of claims arising under its policies." UHC flagrantly and in conscious disregard of the statute, failed to follow the tenets of the aforementioned statute since UHC was aware, via the documentation received by UHC in

May of 2006, the constant and consistent information provided by the provider and by its own internal documentation. Moreover, UHC's internal documents reveal that they were informing the provider that they would process the claim but to allow thirty days when Nebraska law mandates processing within fifteen days. UHC, in conscious disregard, flagrantly violated Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), and 44-1540(7).

97. Pursuant to Title 210 NAC Ch. 61 (008.02), an insurer is required to provide a reasonable explanation for the delay within fifteen days if a claim is denied and with a reasonable explanation for the delay and every thirty days thereafter. The explanations, if provided at all, were baseless and unreasonable in all instances.

G. 06-1034

98. Title 210 NAC Ch. 61 (003.02) states that, for purposes of the Unfair Claims Settlement Practice Regulation, "Beneficiary" means a party entitled to receive the proceeds or benefits occurring under the policy in lieu of the insured but shall not include a medical services provider receiving an assignment of proceeds."

99. Title 210 NAC Ch. 61 (003.04) states that, for purposes of the Unfair Claims Settlement Practice Regulation, "Claimant" means an insured, or the beneficiary and includes a designated legal representative or a member of the insured's immediate family as designated by the insured, making a claim under a policy."

100. Title 210 NAC Ch. 61 (007.01) states that "Every insurer shall, within fifteen (15) days of receipt of proof of loss from a claimant, initiate investigation of the claim."

101. Title 210 NAC Ch. 61 (007.02) establishes the standards for prompt settlement of claims as follows:

> The insurer's standards for claims processing shall be such that notice of claim or proof of loss submitted against one policy issued by that insurer shall fulfill the insured's obligation under any and all similar policies issued by that insurer and specifically identified by the insured to the insurer to the same degree that the same form would be required under any similar policy. If additional information is required to fulfill the insured's obligation under similar policies, the insurer may request the additional information. When it is apparent to the insurer that additional benefits would be payable under an insured's policy upon additional proofs of loss, the insurer shall communicate to and cooperate with the insured in determining the extent of the insurer's additional liability.

102. On August 7, 2006, the Department received a consumer complaint that UHC failed to pay a claim. On August 9, 2006, the Department investigator wrote UHC requesting information, including a request that UHC provide dates of contact with the complainant and documents to support compliance with Chapter 61.

103. On September 5, 2006, UHC responded. UHC failed to respond within fifteen working days as required by Neb. Rev. Stat. §§44-1524 and 44-1525(11).

104. In the September 5, 2006 response provided by UHC, UHC stated that it had received the claim from Providence Medical Center (PMC) on October 26, 2005. The claim processed on November 8, 2005 and was incorrectly denied as being global to services that were rendered on the same day. UHC admitted that after review of the claim history, it determined that this specific claim was processed incorrectly as no other services were performed on this day. The claim was received on October 26, 2005 and not paid until August 29, 2006. This constitutes flagrant and conscious disregard of Neb. Rev. Stat. §§44-1539, 44-1540(4) and 44-1540(8) and multiple violations of Title 210 NAC Ch. 61 (007.01) and (008.03).

105. According to the UHC response to the Department investigator, Providence Medical center contacted UHC on November 28, 2005, to inquire about the claim. According to UHC, UHC was informed "that the claim was denied as not separately reimbursable even though no other services had been provided..." The issue was sent for review. According to the notes from PMC, PMC discussed this issue with UHC and was told the claim was being reviewed by for re-pricing.

106. On December 30, 2005, the complainant contacted UHC with regard to the claim. During the call, the complainant was informed that the claim had been processed and denied as not separately reimbursable. UHC failed to send out any other documentation to the complainant in violation of Neb. Rev. Stat. §§44-1539, 44-1540(2) and Title 210 NAC Ch. 61 (006.01).

107. On February 8, 2006, PMC contacted UHC about the status of the claim. Surprisingly, UHC realized that the complainant's coverage had been incorrectly *terminated* for a period of six days. Still, UHC stated that it believed that the claim was denied correctly even though, as UHC admitted in the September 6, 2006 letter, the explanation of benefits statement sent to the complainant and to PMC did not denote a denial based on a lack of coverage. The complainant had coverage at the time of the claim. UHC actions or inactions violated Neb. Rev. Stat. §§44-1539, 44-1540(2), 44-1540(3), 44-1540(4) and Title 210 NAC Ch. 61 (007.01), (007.02), (008.01), (008.02), and (008.03).

108. On April 18, 2006, PMC contacted UHC regarding the status of the claim. UHC reviewed the complainant's claim history and UHC asserted that the claim had been processed on February 20, 2006 for a date of service of June 7, 2005, and not June 5, 2005. UHC admitted that this was in error. This is a flagrant and conscious disregard of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(7), and 44-1540(8).

109. On May 23, 2006, PMC contacted UHC again about the status of the claim and was told that the claim was still under review. Since the claim should have been paid in the first instance and UHC failed to provide documentation, this conduct is flagrant and in conscious disregard of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), 44-1540(7), and Title 210 NAC Ch. 61 (006.01), (007.01), (007.02), (008.01), and (008.02).

110. On September 6, 2006, a Department investigator contacted UHC with further questions. Specifically, Investigator Williamson asked UHC to "provide additional information and documents showing *how* this claim was handled in compliance with Nebraska Regulation, Chapter 61." UHC responded on October 2, 2006 via fax. In their response, UHC only stated that they believed that "the following provisions of Chapter 61 are controlling in this case: (003.02), (003.04). (Definition omitted). UHC did not provide any other information. The answer did not address the question, and constitutes a flagrant and conscious disregard of Neb. Rev. Stat. §§44-1524 and 44-1525(11).

III.

UHC MARKET CONDUCT REPORT

A. COMPLAINT HANDLING

i.
UHC Failed to Record the Complaints in the Required Format on UHC's Complaint Register

111. Nebraska Unfair Trade Practice Compliant Register regulation, specifically Title 210 NAC Ch. 21 (003) states that "Attachment A or this Regulation sets forth the minimum information required to the be contained in a person's complaint record in order for it to comply with the statute. Refinements and additions to the information specified therein may, of course,

be maintained in such complaint record. Attachment B of this Regulation contains an explanation of the various headings, codes and other notations contained in Attachment A. The codes are used in order to simplify both the identification of the action underlying the complaint and the keeping of records."

112. Title 210 NAC Ch. 21 (004) states, "Attachment A is the suggested format for the complaint record required to be maintained by the statute and this Regulation. Refinements, deviations from or additions to this suggested format are permitted so long as the minimum information contemplated by such format can be obtained for Insurance Department review within a reasonable time following a request thereof by an authorized representative of the Department." **Also see** Attachments A & B.

113. The Department examiners, while conducting the onsite examination of UHC, found that there was not a Complaint Register available with information required by Neb. Rev. Stat. §§44-1524, 44-1525(9) and Title 210 NAC Ch. 21 (003), (004) and (007) Attachments A & B.

ii.

UHC failed to take Adequate Steps to Finalize and Dispose of the Complaint(s) in Accordance with Applicable Statutes, Rules and Regulations, and Contract Language

114. Neb. Rev. Stat. §44-1525(1)(d) states, in relevant part, that it shall be an unfair trade practice act in the business of insurance if an insurer makes, issues, circulates or causes to be made, issued, or circulated any estimate, illustration, circular, statement, sales presentation, omission or comparison which misleads as to or misrepresents the financial condition of any insurer.

115. Neb. Rev. Stat. §44-1525(2) states that it shall be an unfair trade practice is an insurer makes, publishes, disseminates, circulates, or places before the public, or causes, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance or with respect to any insurer in the conduct of his or her insurance business which is untrue, deceptive, or misleading.

116. Title 210 NAC Ch. 61 (004.01) states that "[t]he insurer shall maintain claim data that is accessible and retrievable for examination. An insurer shall be able to provide the claim number, linje of coverage, date of loss and date of payment of the claim, date of denial or date closed without payment. This date must be available for all open and closed files for the current year an the two preceeding years."

117. Title 210 NAC Ch. 61 (004.02) states that "[d]etailed documentation shall be contained in each claim file in order to permit reconstruction of the insurer's activities relative to each claim."

118. Title 210 NAC Ch. 61 (004.03) states that "[e]ach relevant document within the claim file shall be noted as to the date received, date processed or date mailed."

119. In three complaint files examined onsite by the Department, correspondence sent by UBH to a consumer referenced UBM rather than correctly identifying UHC as the underwriting company, in violation of Neb. Rev. Stat. §§44-1524, 44-1525(1)(a), 44-1525(1)(d), and 44-1525(2).

120. One complaint to UHC was in a file that revealed that UHC had problems with its certified mail process because the mail was lost. The Department of Insurance had previously placed UHC on a "Corrective Action Plan" for this *very* same issue. It was noted during the examination that UHC continued to have significant difficulties with losing their certified mail. UHC's conduct violated Title 210 NAC Ch. 61 (006.01), (006.02), and (006.03).

121. UHC did not address all salient issues contained in an inquiry from the Department stemming from a consumer complaint file logged with the Department, in violation of Neb. Rev. Stat. §§44-1524, 44-1525(11) and Title 210 NAC Ch. 61 (006.02).

122. UHC, in a complaint file, revealed that a first-level appeal review panel approved benefits; however, UHC failed to process payment of the approved benefits, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(1), 44-1540(2), 44-1540(3), and 44-1540(8).

123. The Department examiners also noted that UHC provided incorrect and/or incomplete information in three complaint responses to the Department and failed to provide documentation verifying that UHC's computer system had been corrected to recognize modifiers on electronically submitted claims. This violates Neb. Rev. Stat. §§44-1524, 44-1525(11), and Title 210 NAC Ch. 61 (004.01), (004.02), (004.03), and (006.02).

iii

UHC Failed to Respond to Complaints in Accordance with Applicable Statutes, Rules and Regulations

124. Title 210 NAC Ch. 61 §008 (008.04), states that, "[w]ith each claim payment, the insurer shall provide to the insured an Explanation of Benefits that shall include, if applicable, the name of the provider or services covered, amount charged, dates of service, and a reasonable explanation of the computation of benefits."

125. The "Preferred Provider" provisions, Neb. Rev. Stat. §44-4109 states that "[a]n insurer or a participant in an insurance arrangement may enter into contracts to purchase health services on a bid or negotiated basis with health providers at alternative rates of reimbursement and offer such benefit to insureds. Such insurers and participants in insurance arrangements may offer or administer a health benefit plan including preferred provider policies or contracts which limit the number and types of providers of health services eligible for payment as preferred providers under such policies or contracts. Insurers and participants in insurance arrangements may establish terms and conditions which shall be met by a provider of health services in order to qualify for payment as a preferred provider under such policies or contracts. Such terms and conditions may include provisions which identify the method of payment for services, including, but not limited to, development of prospective reimbursement systems."

126. In addtion, The Insurers Examination Act, Neb. Rev. Stat. §44-5905(2)(b)(i)(B) states that "[e]very company or person subject to the act shall retain market conduct records for four years following the completion of a transaction relating to the insurance business and affairs of such company or person. For purposes of this subdivision, market conduct records means all books, records, accounts, papers, documents, and computer or other recordings relating to transactions with insureds, certificate holders, claimants, insurance producers, other insurers, subrogees, and subrogors and recordings related to its trade practices, underwriting, rate and form practices, advertising, regulatory matters, and other affairs of such company or person."

127. The Managed Care Plan Network Adequacy Act, Neb. Rev. Stat. §44-7107 requires that a health carrier have a contract with an intermediary.

128. The Department of Insurance found that the cover page of the "Certificate of Coverage" for UHC lists both UHC and UHM as carriers. This is an incorrect statement of the policy and a violation of Neb. Rev. Stat. §§44-1524 and 44-1525(1)(a) and 44-1525(2).

129. The Department examiners discovered that UHC failed to respond to two letters investigators of the Nebraska Department of Insurance, in violation of Neb. Rev. Stat. §44-1524 and §44-1525(11) and Title 210 NAC Ch. 61 (006.02).

130. UHC engaged in a practice whereby it gave pre-authorization for provider visits to new patients to determine a diagnosis. However, if the claim was then received with a non-covered diagnosis code, UHC's computer system denied coverage. This practice is a clear violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

131. In one complaint, the member's deductible had been applied twice, due to a claim system change by UHC. This practice violated of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

132. In reviewing other files, the Department examiners found that the explanation of benefits did not correctly reflect the number of days pre-authorized or the number of days that were denied. Title 210 NAC Ch. 61 (008.04) requires that an explanation of benefits include a reasonable computation of benefits. UHC claimed that it was a claims processor issue; nonetheless, this is a practice for which UHC is responsible, and constitutes violations of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), and Title 210 NAC Ch. 61 (008.04).

133. In one file reviewed by a Department examiner, UHC failed to provide its members access to a list of UBH providers in violation of Neb. Rev. Stat. §44-4109(5), 44-7105(2), 44-7106(1), and 44-7106(2)(a).

134. Five claim files reviewed by Department examiners revealed that UHC failed to maintain claim documentation as required by Neb. Rev. Stat. §44-5905(2)(b)(i)(B) and Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

135. In six complaint files examined, UHC did not handle payment of benefits within the time requirements of Title 210 NAC Ch. 61 (008.03) and in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(8) and Title 210 NAC Ch. 61 (008.03).

136. In several files reviewed, Department examiners noted that UHC failed to cite in the "Certificate of Coverage" form, the correct time requirements for processing a claim, as required in Title 210 NAC Ch. 61 (008.03).

137. In yet another complaint file, UHC was unable to locate a letter sent to a provider, as well as the copy that was sent to the member that requested additional information and also explained the delay in processing the claim. UHC admitted that the claims processor might not have followed proper protocol. This practice constitutes a violation of Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

138. In yet another file reviewed by a Department examiner, UHC did not adequately document phone calls, as required under Nebraska law. This conduct is a fundamental violation of law, specifically Neb. Rev. Stat. §44-5905 (2)(b)(i)(B), Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

139. A Department examiner also noted UHC's vendor failed to acknowledge the member's grievance as required by Neb. Rev. Stat. §44-7308.

140. During the examination, the Department discovered that a transaction processor failed to review UHC's coordination of benefits screen, which would have advised the processor

that the member had two policies and prompted the correct payments on the claim. This conduct is a violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

141. In yet another file examined by the Department, UHC incorrectly advised a member that the grievance review appeal process would take 3-6 weeks, which is an incorrect statement of the law and a violation of Neb. Rev. Stat. §§44-1524, 44-1525(1)(a), 44-1539, 44-1540(1), and 44-7308(2)(a).

142. During the course of the examination, the Department also reviewed certain UHC contracts. It was noted that UHC contracted with a chiropractic network that negotiated and executed provider contracts with UHC on behalf of the providers. UHC violated Neb. Rev. Stat. §44-7107 because it failed to properly document the chiropractic network as an intermediary. UHC, during the course of the Department of Insurance's examination, amended the pertinent contracts but, nonetheless, violated the aforementioned statute.

B. GRIEVANCE PROCEDURES

i.
UHC Failed to Treat as a Grievance and Written Complaint Submitted by or on Behalf of a Covered Person Regarding (1) the Availability, Delivery, or Quality of Health Care Services, Including a Complaint Regarding an Adverse Determination made Pursuant to Utilization Review; (2) Claims Payment, Handling, or Reimbursement for Health Care Services; or (3) Matters Pertaining to the Contractual Relationship between a Covered Person and the Carrier

143. Neb. Rev. Stat. §44-5905(2)(b)(ii) states that "[t]he books, records, accounts, papers, documents, and computer or other recordings described in subdivisions (2)(b)(i)(A) and (B) of this section and maintained in electronic, computer, micrographic, or other form shall be maintained in a form capable of accurate duplication on paper."

144. In addition, Neb. Rev. Stat. §§44-7303(15) defines "grievance" as "a written complaint submitted in accordance with the health carrier's formal grievance procedure by or on

behalf of a covered person regarding any aspect of the managed care plan, relative to the covered person, such as: (a) Availability, deliver, or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review; (b) Claims payment, handling, or reimbursement for health care services; or (c) Matters pertaining to the contractual relationship between a covered person and a health carrier;"

145. Neb. Rev. Stat. §44-7306 establishes the requirements for grievance register as follows:

> (1) A health carrier shall maintain in a grievance register written records to document all grievances received during a calendar year. A request for a first-level review of an adverse determination shall be processed in compliance with section 44-7308 but not considered a grievance for purposes of the grievance register unless such request includes a written grievance. A request for a second-level review of an adverse determination shall be considered a grievance for purposes of the grievance register. For each grievance required to be recorded in the grievance register, the grievance register shall contain, at a minimum, the following information: (a) A general description of the reason for the grievance; (b) Date received; (c) Date of each review or hearing; (d) Resolution at each level of the grievance; (e) Date of resolution at each level; and (f) Name of the covered person for whom the grievance was filed.
>
> (2) The grievance register shall be maintained in a manner that is reasonably clear and accessible to the director. A grievance register maintained by a health maintenance organization shall also be accessible to the Director of Regulation and Licensure.
>
> (3) A health carrier shall retain the grievance register compiled for a calendar year for the longer of three years or until the director has adopted a final report of an examination that contains a review of the grievance register for that calendar year.

146. In a claim file reviewed by an examiner, the appeals coordinator erroneously logged the appeal as an HMO Product in violation of Neb. Rev. Stat. §§44-7306(1)(a).

147. The Department examiners also reviewed UBH files. In one UBH file, UBH incorrectly treated a grievance as merely an inquiry, in violation of Neb. Rev. Stat. §§44-7303(15) and 44-7308.

148. The UBH "Utilization Management Program Description" provides the procedures for UBH to make care determinations. The procedure examines whether or not a certain level of care meets specific criteria. If it does not, the care manage refers the matter to a "second-level reviewer." The customer's provider is informed about this decision and is allowed to provide additional information and then the matter can be reviewed by telephone with a UBH peer reviewer. This is, in reality, a first-level review and must be treated as such. UBH's and UHC's Grievance Procedure Review is in violation of Neb. Rev. Stat. §44-7308.

149. In two grievance files reviewed examiners, documentation could not be found to enable the examiners to *even* review or verify whether or not UHC was in compliance with the Grievance Act, as required by Neb. Rev. Stat. §44-5905(2)(b)(ii) and Title 210 NAC Ch. 61 (004.01), (004.02) and (004.03).

150. In two grievance files examined, UHC failed to retain copies of a member's request for an appeal, a violation of Neb. Rev. Stat. §44-5905(2)(b)(ii). The aforementioned practices also violated Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

151. In yet another separate grievance file, UHC failed to retain a copy of the member's request for an appeal, in violation of Neb. Rev. Stat. §44-5905(2)(b)(ii).

152. In two files, UHC failed to record and process grievances, as required by Neb. Rev. Stat. §§44-7303(15), 44-7306(1), and 44-7308(2)(a) and (h).

153. In three files, UHC process the complaints as first-level grievance appeals, but failed to document the complaints on the grievance register, as required by Neb. Rev. Stat. §§44-7306(1) and 44-7308(2)(a) and (2)(b).

154. In yet another file, specifically a UBH grievance, the grievance register failed to denote the correct name of complainant in violation of Neb. Rev. Stat. §44-7306(1)(f).

155. UHC also failed, in one file, to handle an appeal request submitted via a provider on behalf of the member as a first-level grievance as required by Neb. Rev. Stat. §44-7308(1).

ii.
UHC Failed to Conduct First-Level Reviews of Grievances in Compliance with Statutes, Rules, and Regulations

156. Powers of the Department provisions, Neb. Rev. Stat. §44-101.01 states:

> The Department of Insurance shall have general supervision, control, and regulation of insurance companies, associations, and societies and the business of insurance in Nebraska, including companies in process of organization. The Director of Insurance shall be the chief administrative officer of the department. The director shall have the power and duty to enforce and execute all the insurance laws of this state and to adopt and promulgate all needful rules and regulations for the purpose of carrying out the true spirit and meaning of Chapter 44 and all laws relating to the business of insurance and, to that end, may authorize and empower an assistant or employee to do any and all things that he or she may do and on his or her behalf, and he or she shall see that all laws respecting insurance companies and insurance agents are faithfully executed. The director or his or her representative shall issue all certificates and licenses as provided for in Chapter 44. If the applicant is an individual, the application for a certificate or license shall include the applicant's social security number. The director and his or her authorized representative shall have the power and authority to do all things and to perform all acts the department is given the power and authority to do.

157. In ten files examined onsite by the Department, UHC's written decision was not sent within 15 days and furthermore, UHC failed to even provide a written extension request to the member as required by Neb. Rev. Stat. §§44-7308(2)(a) and 44-7310(3).

158. In one file, UHC stated that they would complete their review no later than thirty days. This statement constitutes a violation of Neb. Rev. Stat. §§44-1524, 44-1525(1)(a) and 44-7310(3), which requires a written decision in fifteen days.

159. In another file, benefits were due but were not processed, in violation of Neb. Rev. Stat. §§44-1539 and 44-1540(3).

160. In one instance, UHC's written decision contained incorrect information by quoting incorrect benefits, which violated Neb. Rev. Stat. §44-7308(3)(c). Additionally, this is a violation of Neb. Rev. Stat. §§44-1524 and 44-1525(1)(a).

161. A UBH grievance file revealed that due to numerous errors by the appeals coordinator, which included not entering the authorization at the time the appeal was overturned and not requesting the reprocessing of the claim, such that the claim was not reprocessed until approximately six months after the appeal determination, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(4). Additionally, this violated Title 210 NAC Ch. 61 (008.03) twelve times.

162. In other instances, the Department examiners learned that UHC used incorrect co-insurance percentages after the Out of Pocket had been satisfied, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

163. A UBH grievance file reviewed by on Department examiner revealed a three-month delay in a response to a member due to improper routing of the grievance, constituting six violations of Neb. Rev. Stat. §44-7308(2)(a).

164. In thirteen grievance files, UHC did not provide, or could not locate, an acknowledgment letter to the claimant, or the letter was late, in violation of Neb. Rev. Stat.

§§44-1524, 44-1525, 44-7308(2)(b), 44-5905(2)(b)(ii), and Title 210 NAC Ch. 61 (004.01), (004.02) and (004.03).

165. In another file, UHC did not provide the member with their rights and requirements for obtaining a second-level review, in violation of Neb. Rev. Stat. §§44-7308(3)(f)(i) and 44-7308(3)(f)(ii).

166. A UHC file revealed that a written decision gave incorrect quotes from the "Certificate of Coverage." This conduct is a violation of Neb. Rev. Stat. §§44-1524, 44-1525(1)(a) and 44-1525(2).

167. Another file revealed that a written decision had misquoted how benefits were processed, which is a violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-7308(c).

168. In four grievance files, the written decisions did not contain the qualifying credentials of the person acting as reviewer, as required by Neb. Rev. Stat. §44-7308(3)(a).

169. A Department examiner noticed another disclosure problem as UHC failed to advise a member that benefits had been previously considered when UHC composed their written decision letter, in violation of Neb. Rev. Stat. §§44-7308(3)(c) and 44-7308(3)(d).

170. In another file, UHC failed to return calls to a member in violation of Title 210 NAC Ch. 61 (006.01). Additionally, UHC did not provide the member with information regarding the member's rights to file an appeal when the member contacted UHC expressing dissatisfaction with the handling of a claim, which is in violation of Neb. Rev. Stat. §44-7308(f)(ii).

171. In two grievance files reviewed upon examination by the Department, UHC acknowledged that the appeals coordinator failed to address all of the members' concerns and did

not provide all required information, in compliance with the requirements of Neb. Rev. Stat. §§44-7308(3)(b), 44-7308(3)(c), 44-7308(3)(d), 44-7308(3)(e), 44-7308(3)(f) and 44-7308(3)(g).

172. A Department examiner noted that in an acknowledgement letter sent by UBH, it incorrectly stated that there were no notes in UHC's system regarding calls to their Care Management Center in violation of Neb. Rev. Stat. §44-7308. UHC's letter also failed to contain information required by Neb. Rev. Stat. §44-7308(2)(b).

173. Another grievance file revealed that UHC failed to follow grievance procedures per Neb. Rev. Stat. §44-7308(1) and 44-7308(2)(a), by not issuing a written decision within the applicable timeframe.

174. Another file denoted that UBH incorrectly found that the member had another insurance policy and thus improperly denied benefits, this subsequently caused a collection action against the insured. This violates Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(4). Additionally, in this same file, the initial response by UBH did not comply with Neb. Rev. Stat, §44-7308(2)(b), because it did not have an acknowledgement letter sent out within three days.

175. In another instance reviewed by the Department, UHC admitted that UBH did not properly deny claims for medical necessity from one particular provider, because the facility would cease providing care to UBH members. The Department of Insurance did not approve this grievance procedure. This selective practice of paying non-covered claims of a certain provider and not other providers is unfair to member and constitutes a violation of Neb. Rev. Stat. §§44-101.01, 44-1524, 44-1525(1)(a).

176. Certain UBH grievance files were reviewed by the Department examiners, in which the claims exceeded the out-of-pocket (OOP) maximum. The Department's examiners

found claims that had met the OOP maximum were processed with the incorrect co-insurance percentage, in violation Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(4).

177. In another file, additional monies were paid to the facility as an adjustment on the co-pay amounts previously applied. UBH's claim system retention was functioning improperly thus causing UHC's computer system to improperly calculate the OOP amounts in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(4).

iii.
UHC Failed to Conduct Second Level Reviews of Grievances in Accordance with Statutes, Rules, and Regulations

178. Standard Provisions Form, Neb. Rev. Stat. §44-513 states that "Whenever any insurer provides by contract, policy, certificate, or any other means whatsoever for a service, or for the partial or total reimbursement, payment, or cost of a service, to or on behalf of any of its policyholders, group policyholders, subscribers, or group subscribers or any person or group of persons, which services ay be legally performed by a person licensed in this state for the practice osteopathic medicine and surgery, chiropractic, optometry, psychology, dentistry, podiatry, or metal health practice, the person rendering such service or such policyholder, subscriber or other person shall be entitled to such partial or total reimbursement, payment, or cost of such service whether the service is performed by a duly licensed medical doctor or by a duly licensed osteopathic physician, chiropractor, optometrist, psychologist, dentist, podiatrist, or mental health practitioner. This section shall not limit the negotiation of preferred provider policies and contracts under sections 44-4101 to 44-4113."

179. General Provisions Covering Life, Sickness and Accident Insurance, Neb. Rev. Stat. §44-792(5)(b) states, "Serious mental illness means, on and after January 1, 2002, any

mental health condition that current medical science affirms is caused by a biological disorder of the brain and that substantially limits the life activities of the person with the serious mental illness. Serious mental illness includes, but is not limited to (i) schizophrenia, (ii) schizoaffective disorder, (iii) delusional disorder, (iv) bipolar affective disorder, (v) major depression, and (vi) obsessive compulsive disorder."

180. In examining whether or not UHC conducted second-level reviews of grievances in accordance with the law, the Department reviewed several applicable files and none of them passed examination. In two files, UHC failed to provide the member with the required written notification of all information, as required by Neb. Rev. Stat. §44-7309(3)(b). In those files, UHC failed to document that all necessary paperwork was sent to complainant prior to the hearing, in violation of Neb. Rev. Stat. §44-7306 and Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

181. In two files, UHC did not conduct a second level hearing within the 45 working day requirement of Neb. Rev. Stat. §44-7309(3)(a).

182. UHC, in four written grievance decisions, incorrectly cited Nebraska law by stating that a second level review must take place in 15 days, rather than the correct standard of 45 days. This violated Neb. Rev. Stat. §§ 44-1524, 1525(1)(a) and 44-7309(3)(a).

183. In two files, UHC informed the insured that they could have a second-level review via phone, but failed to tell them, as they must, that the insured had a right to participate in person, as required by Neb. Rev. Stat. § 44-7309(3)(a).

184. In one file reviewed by the Department's examiners, UBH failed to provide appropriate coverage for mental illness, which is biological in nature in violation of Neb. Rev. Stat. §44-513, 44-792(5)(b), 44-1524, 44-1539 and 44-1540(3). Eventually, UBH paid the claim

after the second level appeal, however, UBH stated during the Department's examination, that the reason for the eventual payment, after the second-level review, was because of a change to the "Certificate of Coverage" (COC); however, the COC was not, in fact, changed. Both COCs contained exclusions; however, coverage would have been applicable due to the Serious Mental Illness Rider. UBH continued to fail to provide coverage for mental illness, which is biological in nature, and in violation of Neb. Rev. Stat. §§44-792(5)(b) and 44-513. Additionally, UBH also violated Neb. Rev. Stat. §§44-1524, 44-1525(11) for misleading the Department, 44-1539, 44-1540(3) and Title 210 NAC Chapter 61 (006.02), by providing an answer that was not reasonable or, for that matter, accurate.

185. UHC incorrectly informed a member in one grievance that it was past the timeline for a second-level appeal, which is in violation of Neb. Rev. Stat. §§44-7308 and 44-7309.

186. A grievance file revealed that the voting panel used during the grievance advisory panel review did not comply with Neb. Rev. Stat. §44-7309(2)(b), which requires that the majority of the persons reviewing a grievance involving an adverse determination are health care professionals who have appropriate expertise. Only one panel member had such expertise.

iv.
UHC Failed to Handle Grievances Involving Adverse Utilization Review Determinations in Compliance with the Statutes, Rules and Regulations

187. In two files, UHC's written decisions of the first-level appeal of an adverse determination were not provided within the fifteen working days as required by Neb. Rev. Stat. §44-7310(3).

v.

UHC Failed to Comply with Grievance Review Procedures

188. Managed Care Emergency Services Act Neb. Rev. Stat. §44-6827 states:

> For purposes of the Managed Care Emergency Services Act: (1) Closed plan means a managed care plan that requires covered persons to use participating providers under the terms of the managed care plan; (2) Covered benefits means those health care services to which a covered person is entitled under the terms of a health benefit plan; (3) Covered person means a policyholder, subscriber, enrollee, or other individual participating in a health benefit plan; (4) Director means the Director of Insurance; (5) Emergency medical condition means a medical or behavioral condition, the onset of which is sudden, that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such persons or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person; (6) Emergency services means health care services necessary to screen and stabilize a covered person in connection with an emergency medical condition; (7) Facility means an institution providing health care services or a health care setting, including, but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. Facilities does not include physicians' offices; (8) Health benefit plan means a policy, contract, certificate, or agreement entered into, offered, or issued by any person to provide, deliver, arrange for, pay for, or reimburse the costs of health care services. Health benefit plan does not include workers' compensation insurance coverage; (9) Health care professional means a physician or other health care practitioner licensed, certified, or registered to perform specified health care services consistent with state law; (10) Health care provider means a health care professional or a facility; (11) Health care services means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease; (12) Health carrier means an entity that contracts, offers to contract, or enters into an agreement to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a prepaid limited health service organization, a prepaid dental service corporation, or any other entity providing a plan of health insurance, health benefits, or health care services. Health carrier does not include a workers' compensation insurer, risk management pool, or self-insured employer who contracts for services to be provided through a managed care plan certified pursuant to section 48-120.02;

(13) Managed care plan means a health benefit plan, including closed plans and open plans, that either requires a covered person to use or creates financial incentives by providing a more favorable deductible, coinsurance, or copayment level for a covered person to use health care providers managed, owned, under contract with, or employed by the health carrier; (14) Network means the group of participating providers providing services to a managed care plan; (15) Open plan means a managed care plan other than a closed plan that provides incentives, including financial incentives, for covered persons to use participating providers under the terms of the managed care plan; (16) Participating provider means a provider who, under a contract with the health carrier or with its contractor or subcontractor, has agreed to provide health care services to covered persons with an expectation of receiving payment, other than coinsurance, copayments, or deductibles, directly or indirectly from the health carrier; (17) Person means an individual, a corporation, a partnership, an association, a joint venture, joint stock company, a trust, an unincorporated organization, any similar entity, or any combination of the foregoing; and (18) Stabilize means when, with respect to transfer to another facility, the examining physician at a hospital emergency department where an individual has sought treatment for an emergency medical condition has determined, within reasonable medical probability: (a) With respect to an emergency medical condition, that no material deterioration of the condition is likely to result from or occur during a transfer of the individual from the facility; and (b) The receiving facility has available space and qualified personnel for the treatment of the individual and has agreed to accept transfer of the individual and provide appropriate medical treatment.

189. UHC determined that in-network benefits for an out-of-network facility would apply since no in-network facilities were found in the area. However, the claim was denied and payment of benefits was delayed. This is in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), and Title 210 NAC Ch. 61 (006.02).

190. Another file revealed that UHC's procedure allowed for thirty days to make a predetermination on a claim. Nebraska law only allows for fifteen days for a response to all pertinent communications. This is a violation of Title 210 NAC Ch. 61 (006.01).

191. Three grievance files revealed that the explanation of benefits provided by UBH did not provide information to determine the computation of benefits, a disclosure required by Title 210 NAC Ch. 61 (008.04).

192. UHC failed to provide a written determination letter that was sent to complainant, a disclosure required by Neb. Rev. Stat. §§44-1524, 44-1525(11), 44-5905(2)(b)(ii), and Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

193. UHC also failed to document discussions with a claimant regarding benefits, in violation of Title 210 NAC Ch. 61 (004.01), (004.02) and (004.03); and also did not respond to a provider who was requesting benefit information for pre-authorization, in violation of Title 210 NAC Ch. 61 (006.01).

194. In yet another file, UHC was unable to provide a copy of the file closure letter, as required by Neb. Rev. Stat. §§44-5905(2)(b)(ii), 44-1539, 44-1540(13), and Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03). This was in addition to processing the claim incorrectly under Title 210 NAC Ch. 61 (008.03), and having the Customer Care Professional provide inaccurate information to the insured member, in violation of Neb. Rev. Stat. §§44-1524, 44-1525(1)(a), 44-1539, 44-1540(3), and 44-1540(4).

195. In yet another file, UHC could not provide documentation that the provider or member was advised that there was no guarantee of payment when the services had already been authorized through predetermination. This disclosure violation is based upon Title 210 NAC Ch. 61 (004.01), (004.02), (004.03), and (008.02).

196. Other letters in a file did not contain a reasonable written explanation for the delay, as required by Title 210 NAC Ch. 61 (008.02).

197. In one grievance file, the Department of Insurance was unable to verify the tracking of inpatient and outpatient visits with the information provided by UHC, in violation of Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

198. In another grievance file, UHC could not provide documentation that a provider or member was advised that there was no guarantee of payment when the services have been authorized through predetermination, which is a violation of Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

199. Two letters sent by UHC to the insured acknowledged receipt of the claims, but were considered claim delay letters by UHC; however, neither letter contained a reasonable written explanation for the delay, a required disclosure under Title 210 NAC Ch. 61 (008.02).

200. During the review of one grievance file, it was noted that the definition of "Emergency" in the "Certificate of Coverage," GLOSS.01.NE did not comply with Neb. Rev. Stat. §44-6827(5). UHC subsequently changed the definition; but nonetheless, the violation still occurred.

201. Another grievance file revealed that due to a claim processing error, the claim was underpaid, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

202. Yet another file revealed that a claim was not handled timely and was not in compliance with Neb. Rev. Stat. §44-1539, 44-1540(3), 44-1540(4) and, Title 210 NAC Ch. 61 (008.03).

203. UHC also failed to provide certain requested documentation, with regard to the Grievance Procedure, to the Department's examiners. In their November 16, 2006 response to the Report of Examination, UHC admitted that this document was inadvertently not provided, and UHC acknowledged that it was late in providing this document to the Department's examiners. UHC violated Neb. Rev. Stat. §§44-5905(2)(b)(ii), 44-1524, 44-1525(11), and Title 210 NAC Ch. 61 (004.01), (004.02), (004.03) and (006.02).

204. In another file, UHC failed to provide the member with a written explanation that was reasonable and accurate as to why the claim was denied, a disclosure required pursuant to Title 210 NAC Ch. 61 (008.01).

205. Similarly, in a separate file, UHC failed to provide the member with a copy of the response letter requesting additional information, as required by Title 210 NAC Ch. 61 (006.01) and (008.02).

C. NETWORK ADEQUACY

i.
UHC Failed to Demonstrate, using Reasonable Criteria, that it maintains a Network that is Sufficient in Number and Types of Providers to assure that all Services to Covered Persons will be Accessible without Unreasonable Delay.

206. Neb. Rev. Stat. §44-7105(1) states:

> (1) A health carrier providing a managed care plan shall maintain a network that is sufficient in numbers and types of providers to assure that all health care services to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access twenty-four hours per day, seven days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the health carrier, including, but not limited to: Provider-covered person ratios by specialty; primary care provider-covered person ratios; geographic accessibility; waiting times for appointments with participating providers; hours of operation; and the volume of technological and specialty services available to serve the needs of covered persons requiring technologically advanced or specialty care. (a) In any case in which the health carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit and the health carrier shall reimburse the nonparticipating provider at the health carrier's usual and customary rate or at an agreed upon rate. (b) The health carrier shall establish and maintain adequate arrangements to ensure reasonable proximity of participating providers to the business or personal residence of covered persons. In determining whether a health carrier has complied with this provision, the director shall give due consideration to the relative availability of health care providers in the service area under consideration.

207. UHC contracted with UBH to provide mental health and substance abuse coverage for UHC's members. The UBH/UHC contract, which provided mental health/substance abuse coverage, stated that compliance (with the law) would be deemed achieved if 90% of all Covered Persons residing within the Service Area are within 30 miles or 30 minutes of a clinic; however, UBH had indicated that facilities should be within 60 miles of the insured's home as a goal for purposes of rural membership. The rural membership is based on the "UBH Clinical Network Services" that maintains internal recruitment standards that are independent from Customer Contracts for the Membership. UBH and UHC have filed revised contracts with the Department. Nonetheless, the contract violated Neb. Rev. Stat. §44-7105(1).

ii.

UHC Failed to File an Access Plan with the Director for each Managed Care Plan that the Carrier offered in Nebraska and Failed to File an Update when it made a Material Change to an Existing Managed Care Plan. Respondent Failed to make the Access Plan Available on Their Business Premises to Regulators and to Interested Parties, Absent Proprietary Information upon Request.

208. Neb. Rev. Stat. §44-7105(2) states:

> (2) A health carrier shall maintain an access plan meeting the requirements of the Managed Care Plan Network Adequacy Act for each of the managed care plans that the health carrier offers in this state. The health carrier may request the director to deem sections of the access plan as proprietary or competitive information that shall not be made public. For the purposes of this section, information is proprietary or competitive if revealing the information would cause the health carrier's competitors to obtain valuable business information. The health carrier shall make the access plans, absent proprietary information, available on its business premises and shall provide them to the director or any interested party upon request. The health carrier shall prepare an access plan prior to offering a new managed care plan and shall update an existing access plan whenever it makes any material change to an existing managed care plan. The access plan shall describe or contain at least the following: (a) The health carrier's network; (b) The health carrier's procedures for making referrals within and outside its network; (c) The health carrier's process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health

care needs of populations that enroll in managed care plans; (d) The health carrier's efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities; (e) The health carrier's methods for assessing the health care needs of covered persons and their satisfaction with health care services; (f) The health carrier's method of informing covered persons of the managed care plan's services and features, including, but not limited to, the managed care plan's grievance procedures, its process for choosing and changing providers, and its procedures for providing and approving emergency and specialty care; (g) The health carrier's system for ensuring the coordination and continuity of care for covered persons referred to specialty physicians, for covered persons using ancillary services, including social services and other community resources, and for ensuring appropriate discharge planning; (h) The health carrier's process for enabling covered persons to change primary care professionals; (i) The health carrier's proposed plan for providing continuity of care in the event of contract termination between the health carrier and any of its participating providers or in the event of the health carrier's insolvency or other inability to continue operations. The description shall explain how covered persons will be notified of the contract termination or the health carrier's insolvency or other cessation of operations and transferred to other providers in a timely manner; and (j) Any other information required by the director to determine compliance with the provisions of the act.

209. UHC violated Neb. Rev. Stat. §44-7105(2) by not having an access plan for each of their Managed Care Plans that they offered.

iii.

UHC Failed to File with the Director all Required Contract Forms, and any Material Changes to a Contract, Proposed for use with its Participating Providers and Intermediaries

210. Neb. Rev. Stat. §44-7106(2)(b) states:

Every contract between a health carrier that offers closed plans or combination plans having a closed component and a participating provider shall set forth in writing a hold harmless provision specifying protection for covered persons. This requirement shall be met by including a provision substantially to the following: "Provider agrees that in no event, including, but not limited to, nonpayment by the health carrier or intermediary, insolvency of the health carrier or intermediary, or breach of this agreement, shall the provider bill, charge, collect a deposit from, seek compensation, remuneration, or reimbursement from, or have any recourse against a covered person or a person, other than the health carrier or intermediary, acting on behalf of the covered person for health care services provided pursuant

to this agreement. This agreement does not prohibit the provider from collecting coinsurance, deductibles, or copayments, as specifically provided in the evidence of coverage, or fees for uncovered health care services delivered on a fee-for-service basis to covered persons. Nor does this agreement prohibit a provider, except for a health care professional who is employed full time on the staff of a health carrier and has agreed to provide health care services exclusively to that health carrier's covered persons and no others, and a covered person from agreeing to continue health care services solely at the expense of the covered person, as long as the provider has clearly informed the covered person that the health carrier may not cover or continue to cover a specific health care service or health care services. Except as provided herein, this agreement does not prohibit the provider from pursuing any available legal remedy."

211. The 2004 Utilization Management Program Description used by UBH used to process grievances and complaints did not comply with the Health Carrier Grievance Procedure Act, Neb. Rev. Stat. § 44-7301 et. seq. Subsequently, UHC filed a 2005 Utilization Management Program that complied with the Grievance Act.

212. UBH processed mental health claims for UHC; however, UBH did not have a direct contract with UHC. According to UHC, they used a "share agreement". The "share agreement" stated that "The services provided by UBH to UHC are accessed via the Agreement for the Provision of Services between UBH and UHM through the preamble of the agreement covered by benefit plans sponsored or issued by Share and/or Sponsors, as defined in their Agreement. The definition of "Sponsor" was "An entity or person, which may include Share which has sponsored or issued a Benefit Contract and is authorized by United Behavioral Systems (UBS) and Share to us MH/SA Clinics and/or MHSA Providers for the provision of MH/SA Services and/or UM Services to its Covered Persons pursuant to the terms of this Agreement." Additionally, the MH/SA 1002 Agreement under Section 8.5 stated "In the event Share fails to bill the Covered Persons its customary charges or the amount paid by UBS for mental health and/or substance abuse services..." This is a violation of Neb. Rev. Stat. §44-

7106(2)(b), because the "share agreement" did not provide for a hold harmless provision as required by law.

213. The "Certificate of Coverage" under Sections 5 and 5.2 failed to comply with Neb. Rev. Stat. §§44-7308(2)(a), 44-7309(2)(b), 44-7309(3)(f) and 44-7310(1) because it misstated the complaint resolution procedures. UHC subsequently amended the "Certificate of Coverage."

iv.

UHC Failed to Ensure that Covered Persons have Access to Emergency Services Twenty-Four Hours per Day, Seven Days a Week within its Network and Provides Coverage for Emergency Services Outside of its Network.

214. The UBH provider contracts did not contain the appropriate definition of Emergency Medical Condition, as required by Neb. Rev. Stat. § 44-6827(5). The company subsequently filed a Regulatory Attachment-Nebraska Amendment to correct this issue, but, nonetheless, UBH's conduct violated the aforementioned statute.

v.

UHC Failed to have its Intermediaries in Compliance with State Law

215. Neb. Rev. Stat. §44-7103(13) states "Intermediary means a person authorized to negotiate and execute provider contracts with health carriers on behalf of health care providers or on behalf of a network."

216. Neb. Rev. Stat. §44-7108 requires that a health carrier that offers closed plans or combination plans having a closed component shall file with the director ample contract forms proposed for use with its participating providers and intermediaries. The health carrier shall maintain provider and intermediary contracts at its principal place of business in the state, or the

health carrier shall have access to all contracts and provide copies to facilitate regulatory review upon twenty days' prior written notice from the director.

217. UHC originally stated that they did not believe that UBH was an intermediary within the meaning of the statute; however, during the Department's examination, UHC admitted that UBH was an intermediary, pursuant to Neb. Rev. Stat. §§44-7103(13), 44-7107(1), and 44-7108, thus violating the aforementioned statutes.

vi.

UHC's arrangements with Participating Providers Failed to Comply with Nebraska Law

218. UHC violated Neb. Rev. Stat. §§44-1539, 44-1540(4) and Title 210 NAC Ch. 61 (007.01) by having inconsistent text in the "Submission of Claims" portion of contracts, especially in the event additional requested information had not been received within the original timely filing period and was separated from the original claim. The automated claims processing system did not recognize the claim as timely, and if the claim got separated from the additional information the provider would be required to submit the claim through an appeal process.

vii.

UHC Failed to Provide at Enrollment a Provider Directory Listing of all Providers Participating in its Network. Respondent failed to make Available, on a Timely and Reasonable Basis, Updates to its Directory.

219. The mental health/substance abuse providers contracted with UBH were not published in a directory in violation of Neb. Rev. Stat. §44-7105(1).

D. CLAIMS

i.

UHC Failed to Pay Claims in a Timely Manner

220. In specifically reviewing whether or not claims were settled in a timely manner, two files revealed that UHC did not pay benefits timely as required by Neb. Rev. Stat. §§44-1539, 44-1540(8), and Title 210 NAC Ch. 61 (008.03).

221. One claim, subsequently paid, was not paid however within the fifteen-day requirement per Title 210 NAC Ch. 61 (008.03). This late payment violated Neb. Rev. Stat. §§44-1539, 44-1540(8), and Title 210 NAC Ch. 61 (008.03).

222. On one denied claim, UHC received information to verify coverage with respect to pay the claim, but did not process the claim for over sixty days, violating Neb. Rev. Stat. §44-1539, §44-1540(8) and Title 210 NAC Ch. 61 (008.03) four times.

223. UHC incorrectly closed one claim in December of 2003 and did not process the claim until June of 2005. This conduct violated Neb. Rev. Stat. §§44-1539, 44-1540(8) and Title 210 NAC Ch. 61 (008.03) twenty-eight times.

ii.
UHC's Claim Files Failed to be Adequately Documented

224. When examining whether or not claim files were adequately documented, a file revealed that UHC did not retain documentation of one claim file as required by Neb. Rev. Stat. §44-5905(2)(b)(i)(B) and Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

iii.
Respondent Failed to Handle Claim Files in Accordance with Policy Provisions, HIPAA and State Law

225. Small Employer Health Insurance Act Neb. Rev. Stat. §44-5237.01 states:

> (1) Creditable coverage shall mean, with respect to an individual, coverage of the individual under any of the following: (a) A group health plan; (b) Health insurance coverage; (c) Part A or Part B of Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, 42 U.S.C. 1396 et seq., other

> than coverage consisting solely of benefits under section 1928 of the act, 42 U.S.C. 1396s; (e) 10 U.S.C. chapter 55, as such chapter existed on January 1, 2003; (f) A medical care program of the Indian Health Service or of a tribal organization; (g) A state health benefits risk pool; (h) A health plan offered under 5 U.S.C. 8901 et seq.; (i) A public health plan as defined under regulations promulgated by the federal Secretary of Health and Human Services; and (j) A health benefit plan under 22 U.S.C. 2504. (2) Creditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage. (3) Creditable coverage shall not include coverage consisting solely of coverage of excepted benefits as that term is defined in the federal Health Insurance Portability and Accountability Act of 1996, 29 U.S.C. 1191b, and regulations adopted pursuant to the act and in effect on April 19, 1998.

226. In two denied claim files; UHC's disclosure inaccurately stated a 62-day time frame instead of 63 days for purposes of defining creditable coverage in violation of Neb. Rev. Stat. §44-1539, 44-1540(3), 44-1540(4) and 44-5237.01.

227. UHC admitted that the denial of one claim was in error for non-notification because the notification was received within the two-business day requirement, violating Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

228. A denied claim was processed under the incorrect processing platform thus improperly denying services prior to the patient's effective date, a violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

229. UHC's conduct also violated Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4) by incorrectly processing two paid claims as out-of-network provider rates rather than in-network.

iv.

UHC Failed to Handle Denied and Closed-Without-Payment Claims in Accordance with Policy Provisions, HIPAA and State Law

230. The Department noted several violations due to UHC's computer system. For example, UHC admitted a computer system deficiency, which was caused by UHC's failure to timely update for 2004 ASC group changes,. This, in turn, caused the underpayment of a claim, violating Neb. Rev. Stat.§§44-1539 and 44-1540(3). UHC's computer system incorrectly sent the claim payment to the member rather than the provider in violation of Neb. Rev. Stat. §§44-1539 and 44-1540(3). Another claim was processed at 100%, versus the appropriate 90%, due to the coinsurance, in violation of Neb. Rev. Stat.§§44-1539 and 44-1540(3). System errors caused an overpayment of benefits on one paid claim in violation of Neb. Rev. Stat. §§44-1539 and 44-1540(3). A computer system error in the loading of a provider's contract resulted in the incorrect handling of a paid claim, again, violating Neb. Rev. Stat.§§44-1539 and 44-1540(3). UHC incorrectly denied one claim because of system problems in converting from the COSMOS to UNET platforms, also violating Neb. Rev. Stat. §§44-1539 and 44-1540(3).

231. UHC acknowledged that a processor's error in rejecting a compensable claim for assistant surgeon's services. UHC's conduct was not in compliance with the requirements of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), and Title 210 NAC Ch. 61 (008.03).

232. Another denied claim revealed that UHC failed to effectuate prompt, fair, and equitable settlement of the member's submitted claim for benefits, which is a violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

v.

UHC Failed to Comply with the Requirements of The Newborns' and Mothers' Health Protection Act of 1996

233. Neb. Rev. Stat. §44-710.19(1) states that "All individual and group policies of sickness and accident insurance providing coverage on an expense-incurred basis and health maintenance organization contracts shall provide benefits for newly born children of the insured or subscriber from the moment of birth."

234. During the examination, the examiners conducted an analysis of the denied claim listings provided by UHC in order to verify compliance with Neb. Rev. Stat. §44-710.19(1). One denied claim revealed that UHC did not provide applicable benefits for services incurred during the first thirty-one days from the newborn's date of birth as required by law. The claim was denied because "these charges are for services received before the effective date." This constitutes violations of Neb. Rev. Stat. §§ 44-101.01, 44-710.19(1), 44-1539, 44-1540(3) and 44-1540(4).

235. In five denied newborn claims; UHC did not provide applicable benefits for services incurred during the first thirty-one days from the newborns' dates of birth as required by law. This practice is a violation of Neb. Rev. Stat. §§44-101.01, 44-710.19, 44-1539, 44-1540(3) and 44-1540(4).

236. Due to a computer system error, one denied claim was processed under the incorrect claim-processing platform, violating Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

237. Another manually processed denied claim revealed that the paid amounts were not entered; therefore, no payment was made, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4). On yet another manually processed claim, the processor incorrectly

zeroed out the payment amount. This conduct violated Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

E. COMPANY OPERATIONS/MANAGEMENT

i.
The Company Failed to Monitor the Activities of any Entity that Contractually Assumes a Business Function or is Acting on Behalf of the Company

238. The Third Party Administrators Act Neb. Rev. Stat. §44-5803 states:

> (1) No third-party administrator shall act as such without a written agreement between the third-party administrator and the insurer, and such written agreement shall be retained as part of the official records of both the insurer and the third-party administrator for the duration of the agreement and for five years thereafter. The agreement shall contain all provisions required by the Third-Party Administrator Act except insofar as those provisions do not apply to the functions performed by the third-party administrator. (2) The written agreement shall include a statement of duties which the third-party administrator is expected to perform on behalf of the insurer and the lines, classes, or types of insurance for which the third-party administrator is to be authorized to administer. The written agreement shall make provision with respect to underwriting or other standards pertaining to the insurance business underwritten by such insurer. (3) The insurer or third-party administrator may, with written notice, terminate the written agreement for cause as provided in the written agreement. The insurer may suspend the underwriting authority of the third-party administrator during the pendency of any dispute regarding the cause for termination of the written agreement. The insurer shall fulfill any lawful obligations with respect to policies affected by the written agreement, regardless of any dispute between the insurer and the third-party administrator.

239. Neb. Rev. Stat. §44-5807 states:

> (1) If an insurer utilizes the services of a third-party administrator, the insurer shall be responsible for determining the benefits, premium rates, underwriting criteria, and claims-payment procedures and for securing reinsurance, if any. The rules pertaining to these matters shall be provided, in writing, by the insurer to the third-party administrator. The responsibilities of the third-party administrator as to any of these matters shall be set forth in the written agreement between the third-party administrator and the insurer. (2) It shall be the sole responsibility of the insurer to provide for competent administration of its programs. (3) In

> cases when a third-party administrator administers benefits for more than one hundred certificate holders or subscribers on behalf of an insurer, the insurer shall, at least semiannually, conduct a review of the operations of the third-party administrator. At least one such review shall be an onsite audit of the operations of the third-party administrator.

240. The Utilization Review Act, Neb. Rev. Stat. §44-5419 states "On or after July 1, 1993, a utilization review agent may not conduct utilization review upon a covered person in this state unless the agent is granted a certificate by the director. Certificates granted under the Utilization Review Act shall be valid for two years from the date of issuance."

241. At the time of the market conduct examination there was no written agreement between UHC and UBH, a subsidiary of UHG, that set forth the duties and responsibilities of UBH as a Third Party Administrator (TPA), despite the requirements of Neb. Rev. Stat. §§44-5803 and 44-5807. Additionally, when the Department requested documentation of the relationship between the entities, supportive documentation was not provided, in violation of Neb. Rev. Stat. §§44-1524 and 44-1525(11). At the time, there was no direct contract between UBH and UHC. In their role as a TPA, UBH paid and processed the mental health/substance abuse claims without a written agreement between UBH and UHC as required by Neb. Rev. Stat. §44-5803 and 44-5807. UHC responded to the market conduct report on November 16, 2006. In their response, UHC admitted that an agreement has now been arranged between UHC and UBH. Nonetheless, the lack of a previous agreement, as discovered by the Nebraska Department of Insurance's Market Conduct Examination, still constitutes a violation of Neb. Rev. Stat. §§44-5803 and 44-5807.

242. UBH is licensed as a Utilization Review Agent in Nebraska and conducts utilization review in accordance with Neb. Rev. Stat. §44-5416. For a period of time their license

expired; however, UBH continued to operate as a licensed utilization review entity. In the November 16, 2006 response, UHC admitted that the expiration of the license was due to a "clerical error" and the license was subsequently reinstated. Nonetheless, UBH was operating without a license, in violation of Neb. Rev. Stat. §44-5419.

ii.

UHC Failed to Cooperate on a Timely Basis with Examiners Performing the Examination

243. UHC failed to respond in 18 different instances to critique forms submitted by the Market Conduct Examiners. This conduct constitutes eighteen violations of Neb. Rev. Stat. §§44-1524, 44-1525(11) and Title 210 NAC Ch. 61 (006.02).

244. In two responses to critique forms, UHC provided incorrect information. This constitutes two violations of Neb. Rev. Stat. §§44-1524, 44-1525(11) and Title 210 NAC Ch. 61 (006.02).

245. UHC failed to provide accurate listings of the company's grievance and/or complaint files, in violation of Neb. Rev. Stat. §§44-1524, 44-1525(11) and Title 210 NAC Ch. 61 (004.01), (004.02), (004.03), and (006.02).

246. Several files were listed under the wrong legal entity's register/database, including some complaints that were submitted by Petitioner to UHC for their review. This conduct violates Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

247. UHC failed to provide an accurate list of denied and paid claims. UHC advised the Department at the beginning of the examination that there were no claims processed under the COSMOS Platform. In an e-mail dated July 2, 2005, nine months after the claims listings were requested, UHC provided 20 other additional listings of denied and paid claims that had been processed under the COSMOS Platform. This conduct violates Neb. Rev. Stat. §§44-1524,

44-1525(11), and Title 210 NAC Ch. 61 (006.02) eighteen times; as well as Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03) eighteen times.

248. UHC was asked to explain how UBH preserves privacy for UHC and UHM's members. UHC failed to provide the Department a substantive answer, in violation of Neb. Rev. Stat. §§44-1524 and 44-1525(11).

IV.

UHM MARKET CONDUCT REPORT

A. COMPANY OPERATIONS/MANAGEMENT

i.

The Company is Not Adequately Monitoring the Activities of any Entity (MGA, GA, and TPA) that Contractually Assumes a Business Function or is Acting on Behalf of the Company

249. The Unauthorized Insurers Act, Neb. Rev. Stat. §44-2002 states:

> "(1) It shall be unlawful for any insurer to transact insurance business in this state, as set forth in subsection (2) of this section, without a certificate of authority from the director. This section shall not apply to: (a) The lawful transaction of surplus lines insurance; (b) The lawful transaction of reinsurance by insurers; (c) Transactions in this state involving a policy lawfully solicited, written, and delivered outside of this state covering only subjects of insurance not resident, located, or expressly to be performed in this state at the time of issuance, and which transactions are subsequent to the issuance of such policy; (d) Attorneys acting in the ordinary relation of attorney and client in the adjustment of claims or losses; (e) Transactions in this state involving group life and group sickness and accident or blanket sickness and accident insurance or group annuities when the master policy of such groups was lawfully issued and delivered in and pursuant to the laws of a state in which the insurer was authorized to do an insurance business, to a group organized for purposes other than the procurement of insurance, and when the policyholder is domiciled or otherwise has a bona fide situs; or (f) Transactions in this state relative to a policy issued or to be issued outside this state involving insurance on vessels, craft or hulls, cargoes, marine builder's risk, marine protection, and indemnity or other risk, including strikes and war risks commonly insured under ocean or wet marine forms of policy."

250. Neb. Rev. Stat. §44-5809 states, "A third-party administrator shall not enter into any agreement or understanding with an insurer in which the effect is to make the amount of the third-party administrator's commissions, fees, or charges contingent upon savings effected in the adjustment, settlement, and payment of losses covered by the insurer's obligations. This section shall not prohibit a third-party administrator from receiving performance-based compensation for providing hospital or other auditing services. This section shall not prohibit a third-party administrator from receiving compensation based on premiums or charges collected or the number of claims paid or processed."

251. The examination noted that under the terms of the contract with UHM, UBH agreed to provide intermediary utilization review and third party administrator services. UBH also accepted financial risk for ensuring covered persons. UBH was not licensed as an HMO or as an insurer in Nebraska but was nonetheless accepting the financial risk that should have been assumed by UHM. UBH was in violation of Neb. Rev. Stat. §44-2002. Initially, UHM claimed that UBH was not an intermediary. Subsequent responses contradicted this assertion and UHM admitted that UBH was an intermediary. To the extent that UBH was an intermediary, a written contract between UHM and UBH was not in place. UHM and UBH were in violation of Neb. Rev. Stat. § 44-5809.

ii.

The Company Failed to Cooperate on a Timely Basis with Examiners Performing the Examinations

252. UHM failed to provide accurate listings for several claim categories. Several files failed to meet the criteria of the list they were on. UHM admitted that a programming error had occurred resulting in inaccurate data listings. This violates Title 210 NAC Ch. 61 (004.01), (004.02), and (004.03).

253. UHM failed to provide accurate listings of their grievance or complaint files. Several files were listed under the wrong legal entity's register/database, including some complaints that were submitted by the Department. Because of this discrepancy, Department's complaint register is also inaccurate. This violated Neb. Rev. Stat. §§44-1524, 44-1525(9), 44-7306, Title 210 NAC Ch. 21 (003), (004), (007), and Title 210 NAC Ch. 61 (004.01), (004.02), (004.03).

254. UHM generated incorrect claim file listings with regard to accurately documenting the claim in the appropriate claim category. UHM's conduct violated Title 210 NAC Ch. 61 (004.01), (004.02) and (004.03).

B. COMPLAINT HANDLING

i.
UHM Failed to Record all Complaints in the Required Format on the Company Complaint Register

255. UHM failed to have a complaint register and was not in compliance with Neb. Rev. Stat. §§44-1524, 44-1525(9) and Title 210 NAC Ch. 21 (003), (004) and (007), Attachment A & B.

ii.
UHM Failed to Take Adequate Steps to Finalize and Dispose of the Complaint in Accordance with Applicable Statutes, Rules and Regulations and Contract Language

256. UHM failed to provide follow-up information to the Department. The information was promised on or about December 10, 2004, and was not provided until February 17, 2005. This violated Neb. Rev. Stat. §§44-1524 and 44-1525(11) thirty-three times.

C. GRIEVANCE PROCEDURES

i.
UHM Failed to Establish and Maintain Grievance Procedures in Compliance with Statute, Rules and Regulations

257. Uniprise, UHM's service department, had a policy for appeals that stated, "An appeal must be initiated in writing unless the state requires that verbal appeals and complaints be accepted. Access the HMO or Non-HMO Internal State Requirement Grid for further detail." This policy violates the requirements for submitting a request for a first-level grievance review of an adverse decision pursuant to Neb. Rev. Stat. §44-7308(1).

ii.
UHM Failed to Conduct First-Level Reviews of Grievances in Compliance with Statutes, Rules and Regulations

258. In two grievance files, UHM's acknowledgement letter was not sent within three working days of its receipt. This delay is in violation of Neb. Rev. Stat. §44-7308(2)(b).

259. One grievance file revealed that UHM's determination letter was not sent within fifteen working days of its receipt, thus constituting a delay and a violation of Neb. Rev. Stat. §44-7308(2)(a).

260. A grievance file revealed that UHM did not address all of the concerns expressed in a member's grievance appeal in violation of Neb. Rev. Stat. §44-7308(3).

261. Two grievance files revealed that UHM violated Neb. Rev. Stat. §44-7308(3)(a), because UHM did not provide the credentials of the reviewer as disclosed under the aforementioned statute. Those same files violated Neb. Rev. Stat. §44-7308(1) because it could not be determined whether or not the grievance reviewer(s) had appropriate medical expertise.

262. One file revealed that UHM did not request additional time to review a First-Level Grievance Appeal when in was known that the provider was, in fact, providing additional information. This conduct is a violation of Neb. Rev. Stat. §44-7308(2)(a).

263. Two grievance files demonstrated a violation of Neb. Rev. Stat. §44-7308(3), when the appeals coordinator did not follow UHM procedures and guidelines in providing required information in the written decision.

264. The written decision in one grievance file did not provide the instructions on how to request a written statement of the clinical rationale, including the clinical review criteria used to make the determination, as required by Neb. Rev. Stat. §44-7308(3)(e).

iii

UHM Failed to Conduct Second-Level Reviews of Grievances in Accordance with Statutes, Rules, and Regulations

265. In one grievance file, UHM provided the incorrect time requirements for reviewing a second-level grievance appeal in violation of Neb. Rev. Stat. §§44-1524, 1525(1)(a), 44-7309(3)(a).

266. In another file, UHM failed to advise the member of their right to appear in person as required by Neb. Rev. Stat. §44-7309(1).

267. During the market conduct examination, UHM admitted noncompliance with the requirements of Neb. Rev. Stat. §44-7309(2)(b) in one file.

268. UHM further admitted that they could not provide the Department of Insurance examiners copies of the minutes that were taken during a second-level review hearing, a violation of Neb. Rev. Stat. §44-7309(3)(c)(i) and (c)(ii).

iv.

UHM Failed to have Procedures for and Conducts Expedited Appeals in Compliance with Statues, Rules and Regulations

269. Neb. Rev. Stat. §44-7311(9) states, "In any case in which the expedited review process does not resolve a difference of opinion between the health carrier and the covered person or the provider acting on behalf of the covered person, the covered person or the provider acting on behalf of the covered person may submit a written grievance, unless the provider is prohibited from filing a grievance by federal or other state law. A health carrier that offers managed care plans shall review it as a second-level grievance. Except as expressly provided in this section, in conducting the review, the health carrier shall adhere to timeframes that are reasonable under the circumstances."

270. The Uniprise Policy and Procedures for second-level appeals stated, "Urgent appeals do not qualify for second-level review. Refer to the Urgent Appeal SOP for details concerning this process."UHM's policy is a violation of Neb. Rev. Stat. §44-7311(9).

271. UHM's definition of "Emergency" in the "Certificate of Coverage," GLOSS.01.NE does not comply with Neb. Rev. Stat. §44-6827(5).

272. In one grievance file, UHM failed to provide a copy of the file closure letter in violation of Neb. Rev. Stat. §§44-5905(2)(b)(ii) and 44-1540(13).

273. UHM failed to maintain a copy of the closure letter requesting additional information from the provider, a violation of Neb. Rev. Stat. §44-5905(2)(b)(i)(B) and Title 210 NAC Ch. 61 (004.01), (004.02) and (004.03).

D. NETWORK ADEQUACY

i.

UHM Failed to Demonstrate, using Reasonable Criteria, that it maintains a Network that is Sufficient in Number and Types of Providers to assure that all Services to Covered Persons will be Accessible without Unreasonable Delay

274. UHM contracted with UBH to provide mental health and substance abuse coverage for their members. The UBH/UHM contract providing mental health and substance abuse coverage stated, "Compliance with this requirement shall generally be deemed to have been achieved if 90% of all Covered Persons residing within the Service Area are within 30 miles or 30 minutes of a MH/SA Providers." However, UBH has indicated that facilities should be within 60 miles of the insured's home stating, "60 miles is an internal UBH goal for rural membership." The rural membership is based on the "UBH Clinical Network Services" that maintains internal recruitment standards that are independent from customer contracts for the membership. This practice is in violation of Neb. Rev. Stat. §44-7105(1).

ii.

UHM Failed to File an Access Plan with the Director for each Managed Care Plan that the Carrier offers in the State, and Files Updates whenever it makes a Material Change to an Existing Managed Care Plan. UHM failed to make the Access Plans Available: 1) On its Business Premises 2) to Regulators; and 3) to Interested Parties Absent Proprietary Information upon Request

275. UHM averred that they only had one access plan for review. UHM said, "The companies believe that the reference in the Availability Plan to United Healthcare of the Midlands is generic and not entity specific. The Plan is applicable to all products offered in the Nebraska market and it is intended to apply to United HealthCare Insurance Company products as well." Neb. Rev. Stat. §44-7105(2) requires an access plan for each of the managed care plans offered. UHM violated the aforementioned statute.

iii.

UHM failed to file with the Director all required Contract Forms and any Material Changes to a Contract, Proposed for use with its Participating Providers and Intermediaries

276. UBH is a licensed utilization review agent in Nebraska and conducts utilization review per Neb. Rev. Stat. §44-5416, and in accordance with UHM certificates of coverage. UBH's license expired, but, nonetheless, UBH continued to operate as if they had a license. UHM and UBH violated Neb. Rev. Stat. §44-5419.

277. The "2004 Utilization Management Program Descriptions," which UHM, via UBH, used to process grievances and complaints, failed to comply, in total, with the Health Carrier Grievance Procedure Act, Neb. Rev. Stat. §44-7301 et. seq. UHM subsequently provided the Department of Insurance with the 2005 Utilization Management Program which was revised to comply with the Grievance Act.

278. UHM stated that mental health premiums are received from the respective products they underwrite and they remit a capitation fee to UBH. UBH then pays mental health claims from the capitation fees based on provider claims, both paper and electronic. UBH assumed the risk for the mental health/substance abuse services provided through an agreement between the companies. UBH is not a licensed Nebraska insurance company. UBH and UHM's activities violated Neb. Rev. Stat. §§44-101.01 and 44-2002.

279. The agreement in the previous paragraph also stated, "In the event Share fails to pay (UBH) or MH/SA Providers pursuant to this Agreement, UBH or the MH/SA Providers may bill the Covered Persons its customary charges or the amount paid by UBH for mental health and/or substance abuses services." This practice is a violation of Neb. Rev. Stat. §44-7106(2)(b).

280. UHM's "Certificate of Coverage" revealed that the language under Section 5.1-Complaint Procedures states, "you should contact the Company's Customer Service Department, if the issue is not resolved they will explain how to pursue resolution with the Customer Affairs Committee. The Committee will notify you of the complain resolution within 31 days after receipt of the written complaint." This practice is in violation of Neb. Rev. Stat. §§44-7308(2)(a) and 44-7310(1).

281. UHM's "Certificate of Coverage" language, specifically, Section 5.2-Complaint Hearing of the COC stated, "if you are not satisfied with the committee's response, you may request a hearing. A complaint review committee will appointed by the company and will include representatives from physicians, company staff, and members of the community to represent the "Consumer Perspective." The complaint review committee will advise you in writing of its findings within 14 days of the conclusion of the hearing." This practice is in violation of Neb. Rev. Stat. §§44-7309(2)(a), 44-7309(2)(b), and 44-7309(3)(f).

iv.

UHM failed to ensure that Covered Persons have Access to Emergency Services Twenty-Four Hours per day, Seven Days Per Week within its Network and Provides Coverage for Emergency Services outside of its Network Pursuant to Neb. Rev. Stat. §44-6827(5)

282. The provider contracts for UBH did not comply with the definition of Emergency Medical Condition as required by Neb. Rev. Stat. §44-6827(5).

283. The definition of emergency in the "Certificate of Coverage" violated Neb. Rev. Stat. §44-6827(5) by stating, "to avoid jeopardy to the life or health of a Covered Person."

v.

UHM's Contracts with Intermediaries were not in Compliance with Statutes, Rules, and Regulations

284. Initially, UHM stated, "[t]he Companies do not believe that UBH is an intermediary within the meaning of Neb. Rev. Stat. §44-7103(13)." However, during the examination the Company began the process to change the handling of the UBH MH/SA operation. In another response, UHM stated, "UBH does appear to be an intermediary pursuant to Neb. Rev. Stat. §44-7103(13)." UHM violated Neb. Rev. Stat. §§44-7107(1) and 44-7108.

vi.

UHM Arrangements with Participating Providers Comply with Statutes, Rules, and Regulations

285. The Medical Group Participation Agreement, UHC/MG-11.02 NE, Section 7.3 stated that a provider may have to resubmit claims through the appeal process because the system does not recognize that the additional information submitted was timely. This Agreement violates Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

286. UBH provider participation agreements were not consistent in their text. In the event additional requested information from the provider had not been received by UBH within the original timely filing period and was separated from the original claim, the automated claims processing system might not recognize the claim as timely. The provider would be required to submit the claim through the appeal process. This procedure violates Neb. Rev. Stat. §§44-1539 and 44-1540(3).

vii.

UHM Failed to Provide at Enrollment a Provider Directory Listing of all Providers Participating in its Network. It also Failed to Make Available, on a Timely and Reasonable Basis, Updates to its Directory

287. The Health Maintenance Organization Act, Neb. Rev. Stat. §32,135 provides, "Each health maintenance organization shall provide a list of providers to its subscribers upon enrollment and reenrollment. Each health maintenance organization shall provide notice within thirty days of any material change in the operation of the health maintenance organization to its subscribers if the change affects the subscribers directly. An enrollee shall be notified in writing by the health maintenance organization of the termination of the primary care provider who provided health care services to that enrollee. The health maintenance organization shall provide assistance to the enrollee in transferring to another participating provider. Each health maintenance organization shall provide to subscribers information on how services may be obtained and where additional information on access to services can be obtained and a toll-free telephone number for calls within the service area."

288. UHM "Provider Directory" failed to include mental health/substance abuse Providers because providers were not participating with UHM. The "Certificate of Coverage" required all mental health/substance abuse services to be accessed by calling UBH, who was responsible for authorizing and coordinating MH/SA services. UBH stated, "the benefit provided allows for provider access only through the Mental Health/Substance Abuse Designee." The process for provider access violated Neb. Rev. Stat. §44-32,135.

E. UNDERWRITING AND RATING

i.
UHM Failed to Document all Mandated Disclosures in Accordance with Applicable Statutes, Rules and Regulations

289. Neb. Rev. Stat. §44-786 states that "[o]n or after July 1, 1996, any entity which offers any individual or group sickness and accident insurance policy, subscriber contract, health

maintenance organization contract, or hospital, medical, or surgical expense-incurred policy which is delivered, issued for delivery, or renewed in this state shall include obstetricians/gynecologists as primary care physicians if they otherwise qualify as a primary care physician pursuant to the credentialing or recredentialing standards of that entity and they perform all of the functions of a primary care physician according to the terms and conditions of such entity's primary care physician contract."

290. Neb. Rev. Stat. §44-790(5) states, "[p]hysician-prescribed diabetes self-management training and patient management shall be covered at diagnosis, when symptoms or conditions change, and when new medications or treatments are prescribed. Diabetes self-management education must be deemed to be medically necessary by a physician to be eligible for coverage and such coverage shall not exceed five hundred dollars in a two-year period."

291. Neb. Rev. Stat. §44-797(1)(a) states:

> Any individual or group sickness and accident insurance policy, subscriber contract, or group health maintenance organization contract that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas in a manner determined in consultation with the attending physician and the patient. Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and as are consistent with those established for other benefits under the individual or group sickness and accident insurance policy, subscriber contract, or group health maintenance organization contract. Written notice of the availability of such coverage shall be delivered to the participant upon enrollment and annually thereafter.

292. Neb. Rev. Stat. §44-6904(2) states, "[c]reditable coverage shall not include any coverage that occurs before a significant break in coverage. For purposes of this section, a

significant break in coverage shall mean any period of sixty-three consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period shall be taken into account in determining a significant break in coverage."

293. Neb. Rev. Stat. §44-7311(6) states, "[i]n an expedited review, a health carrier shall make a decision and notify the covered person or the provider acting on behalf of the covered person as expeditiously as the covered person's medical condition requires, but in no event more than seventy-two hours after the review is commenced. If the expedited review is a concurrent review determination, the health care service shall be continued without liability to the covered person until the covered person has been notified of the determination."

294. UHM violated Neb. Rev. Stat. §44-7311(6) because the "Certificate of Coverage" did not contain the language required in Neb. Rev. Stat. §44-7311(6). UHM subsequently admitted to this violation.

295. UHM also admitted that the "Certificate of Coverage" did not accurately reflect Neb. Rev. Stat. §44-786, which states that a woman may choose an obstetrician/gynecologist as a primary physician. This practice constitutes a violation of Neb. Rev. Stat. §§44-101.01 and 44-786, 44-1539 and 44-1540(3).

296. UHM further admitted that the "Certificate of Coverage" inaccurately cited the requirements of Neb. Rev. Stat. §44-790(5), which requires that physician-prescribed diabetes self-management training and patient management shall be covered at diagnosis. This inaccuracy is a violation of Neb. Rev. Stat. §§44-101.01, 44-790(5), 44-1539 and 44-1540(3).

297. UHM additionally admitted that the "Certificate of Coverage" inaccurately cited the requirements of Neb. Rev. Stat. §44-797(1)(a), which is the mandated disclosure for

reconstructive procedures following a mastectomy. This is a violation of Neb. Rev. Stat. §§44-101.01, 44-797(1)(a), 44-1539 and 44-1540(3).

298. UHM further admitted that the "Certificate of Coverage" inaccurately cites the requirements of Neb. Rev. Stat. §44-1640 thru §44-1645, which provides continuation of coverage for surviving spouse and dependent children, a violation of that law. In addition to the aforementioned statutes, this also violates Neb. Rev. Stat. §§44-1525, 44-1525(1)(a), and 44-1525(2), 44-1539 and 44-1540(3).

299. Finally, UHM admitted that the "Certificate of Coverage" inaccurately cites the requirements of Neb. Rev. Stat. §§44-5237.01(2) and 44-6904(2), a violation of those statutes in addition to violations of Neb. Rev. Stat. §§44-1539, 1540(3).

F. CLAIMS

i.
UHM Investigations were Not Completed in a Timely Manner

300. In one denied claim, UHM failed to conduct an investigation to determine liability when additional information was provided by the provider, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(7).

301. UHM failed to provide a response to a member on one denied claim, in violation of Neb. Rev. Stat. §§44-1539 and 44-1540(2).

ii.
UHM Investigations were not Settled in a Timely Manner

302. UHM negotiates settlements with providers in a lump-sum manner, rather than paying on individual claims, this practice is in violation of Neb. Rev. Stat. §§44-1539 and 44-1540(3).

303. One claim file, in which the claim was paid, UHM did not process the payment for 22 days after the claim was adjudicated, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(8) and Title 210 NAC Ch. 61 (008.03).

iii.
UHM Failed to Respond to Claim Correspondence in a Timely Manner

304. In one claim file, in which the claim was paid, UHM did not review the additional information that was provided by the member for two claims that UHM had requested. This violates Neb. Rev. Stat. §§44-1539, 44-1540(2), 44-1540(3), and Title 210 NAC Ch. 61 (006.03).

iv.
UHM Failed to Adequately Document Claim Files

305. In four files where claims have been paid, UHM did not provide the member with an explanation of benefits statement, which is a disclosure violation of Title 210 NAC Ch. 61 (008.04).

306. UHM failed to provide to the Department for review a copy of the claim, in one file in which the claim was paid nor did they provide an explanation as to why a copy of the claim documentation could not be provided. This violates Neb. Rev. Stat. §§44-1524, 44-1525(11), 44-5905(2)(c), and Title 210 NAC Ch. 61 (004.01), (004.02), (004.03), and (006.02).

v.
UHM Failed to Handle Claim Files in Accordance with Policy Provisions, HIPAA and State Law

307. UHM admitted to the Department that it failed to accurately process and pay claim benefits because of a computer systems related issue for anesthesia services in violation of Neb. Rev. Stat. §§44-1539, 1540(3) and 44-1540(4).

308. The 1999 Market Conduct Examination Report required UHM to generate annual reports of excess member co-payments, and provide any necessary refunds to member. During the course of the current examination, copies of the 2001, 2002, 2003 and 2004 reports were requested. After several months, UHM provided the reports, although the reports themselves did not indicate the date that they were actually generated. This delay constitutes for each individual report, six violations of Neb. Rev. Stat. §§44-1524 and 44-1525(11). When the Department reviewed the reports, it discovered that the 2003 annual report indicated three members had paid excess co-payments and that refunds were due to the members. However, these refunds were not provided to the members until August 21, 2005, more than one year from when any necessary refund should have been made. UHM violated Neb. Rev. Stat. §§44-101.01, 44-1524, 44-1525(11), 44-1540(3), 44-1540(4), and Title 210 NAC Ch. 61 (006.02), twenty-four times.

vi.
UHM Failed to Handle Denied and Closed-Without-Payment Claims in Accordance with Policy Provisions, HIPAA and State Law

309. Neb. Rev. Stat. §44-6829 states:

> (1) A health carrier which provides a covered benefit for emergency services is, subject to the terms and conditions of the health benefit plan, responsible for charges for medically necessary emergency services provided to a covered person, including services furnished outside the network and services deemed approved under subsection (2) of this section.
> (2) If a treating physician or other emergency department personnel who have provided emergency services to a covered person determine that additional medically necessary services are promptly needed by the covered person and they have requested health carrier approval for such services, the health carrier is deemed to have approved the request if the treating physician or other emergency department personnel involved: (a) Has made a reasonable effort to contact the individual at the health carrier authorized to approve such requests and the health carrier has not provided access to that individual; or (b) Has requested authorization from the individual at the health carrier authorized to approve such requests and the individual has not denied authorization within thirty minutes after the time the request was made, unless the health carrier can document that it

> had made a good faith effort but was unable to reach the emergency physician within thirty minutes after receiving a request for authorization. A request which is deemed approved under this subsection shall be treated as approval for any medically necessary covered benefits that are required to treat the medical condition identified by the treating physician or other emergency department personnel.
> (3) A health carrier may impose a reasonable copayment for emergency services to deter inappropriate use of services of hospital emergency departments if the copayment is the same without regard to whether the health care provider has a contractual or other arrangement with the health carrier.

310. In five claims files where benefits were denied, UHM failed to provide the member with a reasonable and accurate explanation of the basis for the denial, in violation of Neb. Rev. Stat. §§44-1539 and 44-1540(13).

311. One claim was incorrectly denied as duplicate, because the claim for a newborn was processed incorrectly, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(13).

312. For one denied claim, UHM incorrectly denied a resubmitted claim from the provider, because the claim was not submitted in the time frame specified in the provider contract. The member's claim history verified that the provider had originally filed the claim within the time frame specified in the contract. This denial is a violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

313. In two reviewed files, UHM incorrectly denied claims for benefits, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), and 44-1540(13).

314. One denied claim revealed a violation of Neb. Rev. Stat. §44-6829(1). UHM denied an emergency room physician's charge for surgery. UHM subsequently admitted that the UHM's procedures/guidelines were not followed when the charges were initially denied. This also violates Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

315. For another denied claim, UHM received additional information from the physician, which allowed an outpatient emergency room service to be reconsidered. UHM reprocessed the physician fees; however, UHM did not process the related outpatient emergency hospital services until four months after receiving a call from the hospital provider. Additionally, UHM initially provided incorrect information regarding the outpatient emergency services. UHM violated, eight times, Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), and Title 210 NAC Ch. 61 (007.01), (007.02), and (008.03).

vii.
UHM Failed to Comply with the Requirements of the Newborns' and Mothers' Health Protection Act of 1996

316. UHM admitted that it failed to comply with Neb. Rev. Stat. §§44-710.19(1), 44-710.19(3), and Nebraska Bulletin CB-97, when it failed to provide benefits for anesthesia services.

317. One denied claim revealed a violation of Neb. Rev. Stat. §44-710.19(1) because UHM failed to provide applicable benefits for services incurred during the first thirty-one days from the newborn's date of birth. UHM admitted that it had received eligibility information from the group, prior to receiving the claim, which indicated an effective date other than the newborn's date of birth. Since an active eligibility screen existed for the child, UHM's computer system failed to recognize that the newborn required coverage. UHM's conduct also violated Neb. Rev. Stat. §44-1539, 1540(3).

318. In one paid claim file, the member's correspondence met the definition of a complaint per Title 210 NAC Ch. 21 and a grievance as defined in Neb. Rev. Stat. §44-7303(15);

however, UHM failed to act upon the correspondence, in violation of the aforementioned statute and regulation.

G. PROVIDER ISSUES

i.
UHM Failed to Pay Claims in a Timely Manner

319. One provider appeal revealed that UHM failed to affirm or deny the claim within a reasonable time after the investigation was completed, in violation of Neb. Rev. Stat. §§44-1539 and 44-1540(8).

320. In another provider appeal, UHM failed to pay the claim in a timely manner. The date of service was February 5, 2004, and the claim was not paid until April 8, 2005, during the course of the Petitioner's examination. This violated Neb. Rev. Stat. §§44-1539, 44-1540(3), 44-1540(4), 44-1540(8), and Title 210 NAC Ch. 61 (008.03), twenty-six times.

ii.
UHM Failed to Handle Claim Files in Accordance with Policy Provisions, HIPAA and State Law

321. In six different provider appeal files, UHM incorrectly paid claims based upon 2003 contract rates instead of 2004 contract rates; failed to pay based upon the surgical CPT code; originally paid $1, instead of the fee schedule amount; applied the wrong rate for the Room and Board charges in addition to the drug charges; incorrectly processed the claim by not paying at the 50% of eligible expenses standard; and failed to pay a provider the contracted fee. All of these six instances violate Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(4).

iii.

UHM Failed to Handle Denied and Closed-Without-Payment Claims in Accordance with Policy Provisions, HIPAA, and State Law

322. In two provider appeal files, UHM incorrectly denied the claims because the provider was a non-network provider when the provider was actually a network provider. This violates Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(4).

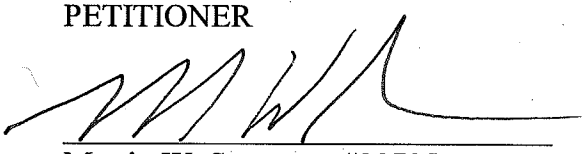
323. Three provider appeal files reflected that UHM wrongly denied claims for non-notification. One of the files involved a claim for emergency room services, and the other file was incorrectly denied because UHM did not notify UBH of a system eligibility problem with the member's eligibility information. These practices violate Neb. Rev. Stat. §§44-1539, 44-1540(3) and 44-1540(4).

324. One file revealed that the original payment was incorrect, in violation of Neb. Rev. Stat. §§44-1539, 44-1540(3), and 44-1540(4).

WHEREFORE, Petitioner will set this matter for hearing to request an order imposing such fines as are allowed by law.

Dated this 7th day of December, 2006.

STATE OF NEBRASKA
DEPARTMENT OF INSURANCE
PETITIONER



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